ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619

October 14, 2016

Ms. Donna K. Davis, Senior Legislative Analyst
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Ms. Davis:

Re: State Plan Amendment #2016-007 – Nursing Facility Payment Methodology

Attached are:

- **Two copies of the Questionnaire For Filing Proposed Rules and Regulations**
- **Two copies of the Financial Impact Statement**
- **Two copies of the policy summary**
- **Two copies of the mark-up rule**
- **Two copies of revised rule**

The Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules is being amended to change policy regarding the payment of a Provisional Rate. The policy changes the methodology used to determine the per diem rate a nursing facility will receive after a change of ownership. The policy also puts a cap on the allowable professional liability insurance at $2,500 per licensed bed.

Please arrange for the rule to be reviewed by the ALC-Administrative Rules and Regulations Subcommittee. If you have any questions or need additional information, please contact Becky Murphy, Policy Development Coordinator, Division of Medical Services, Program Development and Quality Assurance at 501-320-6429 or emailing becky.murphy@dhs.arkansas.gov.

Sincerely,

Dawn Stehle /TAH

RECEIVED
OCT 14 2016
BUREAU OF
LEGISLATIVE RESEARCH

Dawn Stehle
Director

DS:bm

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

RECEIVED

OCT 14 2016

BUREAU OF LEGISLATIVE RESEARCH

DEPARTMENT/AGENCY	Department of Human Services
DIVISION	Division of Medical Services
DIVISION DIRECTOR	Dawn Stehle
CONTACT PERSON	Lynn Burton
ADDRESS	PO Box 1437, Slot S295, Little Rock, AR 72203

PHONE NO. 501-682-1857 **FAX NO.** 501-404-4619 **E-MAIL** lynn.burton@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question <u>completely</u> using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? State Plan Amendment 2016-007

2. What is the subject of the proposed rule? Nursing Facility Payment Methodology Update

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒

   If yes, please provide the federal rule, regulation, and/or statute citation. ______

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

   If yes, what is the effective date of the emergency rule? ______

   When does the emergency rule expire? ______

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules is being amended to change policy regarding the payment of a Provisional Rate. The policy changes the methodology used to determine the per diem rate a nursing facility will receive after a change of ownership. The policy also puts a cap on the allowable professional liability insurance at $2,500 per licensed bed.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: October 3, 2016

Time: 4:30pm

Place: Central Arkansas Library
Lee Room
100 Rock Street
Little Rock, AR 72201

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
October 14, 2016

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
January 1, 2017

12. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain. _____

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Lynn Burton
TELEPHONE NO. 501-682-1857 **FAX NO.** 501-682-3889 **EMAIL:** Lynn.burton@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE SPA 2016-007

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total ______ Total ______

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($967,360)	General Revenue	($1,934,720)
Federal Funds	($2,232,640)	Federal Funds	($4,465,280)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	($3,200,000)	Total	($6,400,000)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ ______

Next Fiscal Year
$ ______

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ (967,360)

Next Fiscal Year
$ (1,934,720)

The policy changes the methodology used to determine the per diem rate a nursing facility will receive after a change of ownership. The policy also puts a cap on the allowable professional liability insurance at $2,500 per licensed bed.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Arkansas Department of Human Services
Long Term Care Manual of Cost Reimbursement Rules Changes
Summary of Substantive Changes

The Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules is being amended to change policy regarding the payment of a Provisional Rate. The policy changes the methodology used to determine the per diem rate a nursing facility will receive after a change of ownership. The policy also puts a cap on the allowable professional liability insurance at $2,500 per licensed bed.

PROPOSED

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

PROPOSED

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the 16 Bed and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

A. Nursing Facilities

PROPOSED

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.

The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90th percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

PROPOSED

3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year costing over $1,000.00 are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

PROPOSED

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.

{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:

A. Constructs a new facility; or
B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.

A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

PROPOSED

4. Rates for Facilities that Change of Ownership

Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be paid as stated below. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a rate as described below or has received a rate as described below in the previous 24 months, the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control or common board members, or has control of or is controlled by the related organization. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

A. Changes of Ownership occurring from July 1 through March 31

1. For facilities that prior to the change of ownership operated with a rate calculated from a cost report whether full year or partial, the new operator will be reimbursed the previous operator's rate as of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

2. For facilities that prior to the change of ownership operated with a provisional rate either initial or revised by a cost report, the new operator will be reimbursed the weighted average actual rate from the state fiscal year of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. The weighted average rate will be calculated from rates calculated from full year cost reports. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

B. Changes of Ownership occurring from April 1 through June 30

Facilities that have a change of ownership from April 1 through June 30 of a State Fiscal Year will be paid an initial rate as described above in Section 2-4

PROPOSED

A. 4. A. 1 and 2. The new operator will be required to submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. A rate will be retroactively adjusted to the per diem calculated as described below.

1. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.
2. The Indirect, Administrative and Operating per diem will be the class rate for the applicable rate period.
3. The Fair Market Rental Payment will consist of a return on equity assuming no debt, a facility rental factor and property taxes and insurance. The per diem will be calculated by dividing the sum of the components above by the greater of the actual occupancy or the required minimum occupancy.

5. Terminating Facilities

Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility.

6. Inflation Index

For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

7. Adjustments to Provider Cost Reports

Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

PROPOSED

must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

A. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

B. Rate Setting

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

PROPOSED

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

Mark Up

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed~~, newly purchased, or newly leased,~~ or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the 16 Bed and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,
2. Working trial balance and related working papers identifying the cost report line each account is included on,
3. Detailed depreciation schedule,
4. Any work papers used to compute adjustments made on the cost report,

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ~~floors and~~ ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.

The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90th percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the ~~facilities~~ facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year costing over $1,000.00 are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.

{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:

A. Constructs a new facility; or

~~B. Affects a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a provisional rate or has received a provisional rate in the previous 24 months, then no additional provisional rate shall be paid and the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor; or~~

~~C.~~B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.

A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.

B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.

C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated ~~have changed ownership~~ or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled~~have changed ownership~~.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

4. Rates for Facilities that Change of Ownership

Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be paid as stated below. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a rate as described below or has received a rate as described below in the previous 24 months, the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control or common board members, or has control of or is controlled by the related organization. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

A. Changes of Ownership occurring from July 1 through March 31

1. For facilities that prior to the change of ownership operated with a rate calculated from a cost report whether full year or partial, the new operator will be reimbursed the previous operator's rate as of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

2. For facilities that prior to the change of ownership operated with a provisional rate either initial or revised by a cost report, the new operator will be reimbursed the weighted average actual rate from the state fiscal year of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. The weighted average rate will be calculated from rates calculated from full year cost reports. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

B. Changes of Ownership occurring from April 1 through June 30

Facilities that have a change of ownership from April 1 through June 30 of a State Fiscal Year will be paid an initial rate as described above in Section 2-4

A. 4. A. 1 and 2. The new operator will be required to submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. A rate will be retroactively adjusted to the per diem calculated as described below.

1. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.
2. The Indirect, Administrative and Operating per diem will be the class rate for the applicable rate period.
3. ~~1.~~3. The Fair Market Rental Payment will consist of a return on equity assuming no debt, a facility rental factor and property taxes and insurance. The per diem will be calculated by dividing the sum of the components above by the greater of the actual occupancy or the required minimum occupancy.

5. Terminating Facilities

Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility. ~~This provision does not apply to the sale or lease of a facility between related parties with common ownership as defined in section 2-1 A. 3 above.~~

~~5~~6. Inflation Index

For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

~~6~~7. Adjustments to Provider Cost Reports

Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

A. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

B. Rate Setting

~~Facility beds newly certified as Home Style beds are eligible for a provisional rate.~~

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

PROPOSED

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

PROPOSED

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the 16 Bed and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

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B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report.

A. Nursing Facilities

PROPOSED

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.

The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90th percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

PROPOSED

3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year costing over $1,000.00 are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.

{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

PROPOSED

A provisional rate will be paid to a provider who:

A. Constructs a new facility; or
B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.

A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

PROPOSED

4. Rates for Facilities that Change of Ownership

Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be paid as stated below. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a rate as described below or has received a rate as described below in the previous 24 months, the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control or common board members, or has control of or is controlled by the related organization. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

A. Changes of Ownership occurring from July 1 through March 31

1. For facilities that prior to the change of ownership operated with a rate calculated from a cost report whether full year or partial, the new operator will be reimbursed the previous operator's rate as of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

2. For facilities that prior to the change of ownership operated with a provisional rate either initial or revised by a cost report, the new operator will be reimbursed the weighted average actual rate from the state fiscal year of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. The weighted average rate will be calculated from rates calculated from full year cost reports. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

B. Changes of Ownership occurring from April 1 through June 30

Facilities that have a change of ownership from April 1 through June 30 of a State Fiscal Year will be paid an initial rate as described above in Section 2-4

A. 4. A. 1 and 2. The new operator will be required to submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. A rate will be retroactively adjusted to the per diem calculated as described below.

1. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.
2. The Indirect, Administrative and Operating per diem will be the class rate for the applicable rate period.
3. The Fair Market Rental Payment will consist of a return on equity assuming no debt, a facility rental factor and property taxes and insurance. The per diem will be calculated by dividing the sum of the components above by the greater of the actual occupancy or the required minimum occupancy.

5. Terminating Facilities

Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility.

6. Inflation Index

For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

7. Adjustments to Provider Cost Reports

Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

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must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

A. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

B. Rate Setting

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

PROPOSED

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

2. Form 6, Section 3 Property

Amounts for depreciation, Rent – Building and Rent – Furniture and Equipment must be identified for historical purposes only. A Fair Market Rental Payment is made in lieu of these expenses.

Line 3-01, Amortization Expense - Capital (Schedule)

Legal and other costs incurred when financing the facility should be amortized over the life of the mortgage. Attach a detail amortization schedule for these costs. These costs are not to be included on the Form 7 depreciation schedule.

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Line 3-02, Depreciation – Fair Market Rental

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. Items costing $300 or more will be capitalized.

Depreciation expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-03, Depreciation – Generator

Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.

Line 3-04, Interest Expense – Fair Market Rental

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to finance the fixed assets or major movable equipment. The total of Line 3-04, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 10.

Interest expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-05, Interest Expense – Generator

Interest paid or accrued on notes the proceeds of which were used to purchase a generator approved by the Office of Long Term Care under Act 1602 of 2001. The total of Line 3-05, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 11.

Line 3-06, Property Insurance

Cost of fire and casualty insurance on facility buildings and equipment.

Line 3-07, Professional Liability Insurance

Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

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	Improvements	to building or plant where the facility is leased and the cost of the changes are incurred by the lessee.
802.60	Depreciation - Generator	Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.10	Interest - Land/Building	Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facilities real property (land and building).
803.20	Interest -Furniture/Equipment	Interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the facility's furniture and equipment.
803.30	Interest - Generator	Interest paid or accrued on notes the proceeds of which were used to purchase generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.40	Interest – Point of Care	Interest expense associated with point of care software applications.
804.00	Property Insurance	Cost of fire and casualty insurance on facility buildings and equipment.
805.00	Insurance - Professional Liability	Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.
806.00	Property Taxes	Cost of taxes levied on the facility's land and buildings.
807.00	Rent - Building	Cost of leasing the facility's real property (land and building).
808.00	Rent - Furniture & Equipment	Cost of leased or rented furniture and equipment for the facility.
809.00	Rent – Point of Care	Rent expense associated with point of care software applications.

QUALITY ASSURANCE FEE

820.00	Quality Assurance Fee	Cost of the quality assurance fee paid monthly to the Department of Human Services.

NON-ALLOWABLE COSTS

831.00	Advertising	Cost of advertisements in magazines, newspapers, trade publications, radio, TV and yellow pages which seeks to increase resident utilization of the nursing facility.
832.00	Bad Debts	Accounts receivable written off as uncollectable.
833.00	Barber & Beauty	Cost directly related to the provision of beauty and barber services to residents. The cost of beauty and barber services provided by facility staff are considered allowable costs and should be recorded in account 731.00.

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

PROPOSED

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed~~, newly purchased, or newly leased,~~ or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the 16 Bed and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ~~floors and~~ ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.

The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90th percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the ~~facilities~~ facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year costing over $1,000.00 are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.
{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:

A. Constructs a new facility; or

~~B. Affects a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a provisional rate or has received a provisional rate in the previous 24 months, then no additional provisional rate shall be paid and the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor; or~~

~~C.~~B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.

A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated ~~have changed ownership~~ or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled~~have changed ownership~~.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

4. Rates for Facilities that Change of Ownership

Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be paid as stated below. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a rate as described below or has received a rate as described below in the previous 24 months, the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control or common board members, or has control of or is controlled by the related organization. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

A. Changes of Ownership occurring from July 1 through March 31

1. For facilities that prior to the change of ownership operated with a rate calculated from a cost report whether full year or partial, the new operator will be reimbursed the previous operator's rate as of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

2. For facilities that prior to the change of ownership operated with a provisional rate either initial or revised by a cost report, the new operator will be reimbursed the weighted average actual rate from the state fiscal year of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. The weighted average rate will be calculated from rates calculated from full year cost reports. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

B. Changes of Ownership occurring from April 1 through June 30

Facilities that have a change of ownership from April 1 through June 30 of a State Fiscal Year will be paid an initial rate as described above in Section 2-4

A. 4. A. 1 and 2. The new operator will be required to submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. A rate will be retroactively adjusted to the per diem calculated as described below.

1. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.
2. The Indirect, Administrative and Operating per diem will be the class rate for the applicable rate period.

~~1.~~3. The Fair Market Rental Payment will consist of a return on equity assuming no debt, a facility rental factor and property taxes and insurance. The per diem will be calculated by dividing the sum of the components above by the greater of the actual occupancy or the required minimum occupancy.

5. Terminating Facilities

Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility. ~~This provision does not apply to the sale or lease of a facility between related parties with common ownership as defined in section 2-1 A. 3 above.~~

~~5~~6. Inflation Index

For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

~~6~~7. Adjustments to Provider Cost Reports

Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

A. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

B. Rate Setting

~~Facility beds newly certified as Home Style beds are eligible for a provisional rate.~~

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

2. Form 6, Section 3 Property

Amounts for depreciation, Rent – Building and Rent – Furniture and Equipment must be identified for historical purposes only. A Fair Market Rental Payment is made in lieu of these expenses.

Line 3-01, Amortization Expense - Capital (Schedule)

Legal and other costs incurred when financing the facility should be amortized over the life of the mortgage. Attach a detail amortization schedule for these costs. These costs are not to be included on the Form 7 depreciation schedule.

Line 3-02, Depreciation – Fair Market Rental

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. Items costing $300 or more will be capitalized.

Depreciation expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-03, Depreciation – Generator

Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.

Line 3-04, Interest Expense – Fair Market Rental

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to finance the fixed assets or major movable equipment. The total of Line 3-04, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 10.

Interest expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-05, Interest Expense – Generator

Interest paid or accrued on notes the proceeds of which were used to purchase a generator approved by the Office of Long Term Care under Act 1602 of 2001. The total of Line 3-05, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 11.

Line 3-06, Property Insurance

Cost of fire and casualty insurance on facility buildings and equipment.

Line 3-07, Professional Liability Insurance

Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

	Improvements	to building or plant where the facility is leased and the cost of the changes are incurred by the lessee.
802.60	Depreciation - Generator	Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.10	Interest - Land/Building	Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facilities real property (land and building).
803.20	Interest -Furniture/Equipment	Interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the facility's furniture and equipment.
803.30	Interest - Generator	Interest paid or accrued on notes the proceeds of which were used to purchase generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.40	Interest – Point of Care	Interest expense associated with point of care software applications.
804.00	Property Insurance	Cost of fire and casualty insurance on facility buildings and equipment.
805.00	Insurance - Professional Liability	Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.
806.00	Property Taxes	Cost of taxes levied on the facility's land and buildings.
807.00	Rent - Building	Cost of leasing the facility's real property (land and building).
808.00	Rent - Furniture & Equipment	Cost of leased or rented furniture and equipment for the facility.
809.00	Rent – Point of Care	Rent expense associated with point of care software applications.

QUALITY ASSURANCE FEE

820.00	Quality Assurance Fee	Cost of the quality assurance fee paid monthly to the Department of Human Services.

NON-ALLOWABLE COSTS

831.00	Advertising	Cost of advertisements in magazines, newspapers, trade publications, radio, TV and yellow pages which seeks to increase resident utilization of the nursing facility.
832.00	Bad Debts	Accounts receivable written off as uncollectable.
833.00	Barber & Beauty	Cost directly related to the provision of beauty and barber services to residents. The cost of beauty and barber services provided by facility staff are considered allowable costs and should be recorded in account 731.00.

Mark up

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed~~, newly purchased, or newly leased,~~ or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the 16 Bed and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ~~floors and~~ ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.

The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90^{th} percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the ~~facilities~~ facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year costing over $1,000.00 are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.
{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:
A. Constructs a new facility; or
~~B. Affects a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a provisional rate or has received a provisional rate in the previous 24 months, then no additional provisional rate shall be paid and the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor; or~~
~~C.~~B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.
A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated ~~have changed ownership~~ or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled~~have changed ownership~~.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

4. Rates for Facilities that Change of Ownership

Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be paid as stated below. If it is determined that a related party relationship exists between the buyer and seller or lessee and lessor, and the provider (facility) is currently receiving a rate as described below or has received a rate as described below in the previous 24 months, the provider will continue to be paid a rate as if the purchase or lease had not occurred. In such instance, the buyer or lessee shall submit all cost reports required by these regulations as if the purchase or lease had not occurred. If the buyer and/or the seller, or lessee and/or lessor consist of an entity, such as a corporation, company, limited liability company, partnership, association, then the related party criteria set forth herein shall apply to each such entity and its principals, shareholders, partners, etc. A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control or common board members, or has control of or is controlled by the related organization. A related party relationship exists when there is common ownership of five percent (5%) or more in both the buyer and seller or lessee and lessor. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

A. Changes of Ownership occurring from July 1 through March 31

1. For facilities that prior to the change of ownership operated with a rate calculated from a cost report whether full year or partial, the new operator will be reimbursed the previous operator's rate as of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

2. For facilities that prior to the change of ownership operated with a provisional rate either initial or revised by a cost report, the new operator will be reimbursed the weighted average actual rate from the state fiscal year of the date of the change of ownership with an inflation factor add on to the direct care, administrative and property components. The weighted average rate will be calculated from rates calculated from full year cost reports. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6. The quality assurance fee will continue to be the multiplier for the date of service billed.

B. Changes of Ownership occurring from April 1 through June 30

Facilities that have a change of ownership from April 1 through June 30 of a State Fiscal Year will be paid an initial rate as described above in Section 2-4

A. 4. A. 1 and 2. The new operator will be required to submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. A rate will be retroactively adjusted to the per diem calculated as described below.

1. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.
2. The Indirect, Administrative and Operating per diem will be the class rate for the applicable rate period.
~~1.~~3. The Fair Market Rental Payment will consist of a return on equity assuming no debt, a facility rental factor and property taxes and insurance. The per diem will be calculated by dividing the sum of the components above by the greater of the actual occupancy or the required minimum occupancy.

5. Terminating Facilities

Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility. ~~This provision does not apply to the sale or lease of a facility between related parties with common ownership as defined in section 2-1 A. 3 above.~~

~~5~~6. Inflation Index

For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket – Without Capital index published by Standard & Poor's DRI published for the quarter ending June 30th of the cost reporting period. The Department will use the %MOVAVG figure identified for the final quarter of the rate period.

~~6~~7. Adjustments to Provider Cost Reports

Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

A. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

B. Rate Setting

~~Facility beds newly certified as Home Style beds are eligible for a provisional rate.~~

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

2. Form 6, Section 3 Property

Amounts for depreciation, Rent – Building and Rent – Furniture and Equipment must be identified for historical purposes only. A Fair Market Rental Payment is made in lieu of these expenses.

Line 3-01, Amortization Expense - Capital (Schedule)

Legal and other costs incurred when financing the facility should be amortized over the life of the mortgage. Attach a detail amortization schedule for these costs. These costs are not to be included on the Form 7 depreciation schedule.

Line 3-02, Depreciation – Fair Market Rental

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. Items costing $300 or more will be capitalized.

Depreciation expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-03, Depreciation – Generator

Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.

Line 3-04, Interest Expense – Fair Market Rental

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to finance the fixed assets or major movable equipment. The total of Line 3-04, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 10.

Interest expense associated with point of care software applications must be reclassified to Line 1-29.

Line 3-05, Interest Expense – Generator

Interest paid or accrued on notes the proceeds of which were used to purchase a generator approved by the Office of Long Term Care under Act 1602 of 2001. The total of Line 3-05, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 11.

Line 3-06, Property Insurance

Cost of fire and casualty insurance on facility buildings and equipment.

Line 3-07, Professional Liability Insurance

Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

	Improvements	to building or plant where the facility is leased and the cost of the changes are incurred by the lessee.
802.60	Depreciation - Generator	Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.10	Interest - Land/Building	Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facilities real property (land and building).
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807.00	Rent - Building	Cost of leasing the facility's real property (land and building).
808.00	Rent - Furniture & Equipment	Cost of leased or rented furniture and equipment for the facility.
809.00	Rent – Point of Care	Rent expense associated with point of care software applications.

QUALITY ASSURANCE FEE

820.00	Quality Assurance Fee	Cost of the quality assurance fee paid monthly to the Department of Human Services.

NON-ALLOWABLE COSTS

831.00	Advertising	Cost of advertisements in magazines, newspapers, trade publications, radio, TV and yellow pages which seeks to increase resident utilization of the nursing facility.
832.00	Bad Debts	Accounts receivable written off as uncollectable.
833.00	Barber & Beauty	Cost directly related to the provision of beauty and barber services to residents. The cost of beauty and barber services provided by facility staff are considered allowable costs and should be recorded in account 731.00.