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The following sections summarize the methods and procedures for determining nursing facility reimbursement rates in the format prescribed by the Department of Health and Human Services (DHHS). Effective July 1, 1999, the Department will use the 1998 cost reports as the basis for setting reimbursement rates for nursing facilities. Complete documentation is found in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000, included as an attachment to this exhibit.

A. Cost Finding and Cost Reporting

1. All nursing facilities are required to report costs for the twelve months ending June 30th of each year.

2. All nursing facilities are required to detail their entire costs for the reporting year, or for the period of participation in the plan (if less than the full cost reporting year) for allowable costs under the Georgia Plan. These costs are reported by the facility using a Uniform Chart of Accounts prescribed by the State Agency and on the basis of generally accepted accounting principles and accrual methods of accounting.

3a. All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency on or before September 30 of the year in which the reporting period ends. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September 30 must submit cost reports on or before December 31 using the most recent complete fiscal year cost data.

3b. All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

4. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.

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5. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 3a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.

B. Audits

1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:

    (a) The development of standards of reasonableness for each major cost center of a nursing facility;

    (b) The development of a computerized desk review process for the submitted uniform cost reports; and

    (c) The development of a detailed on-site audit plan, using generally accepted auditing standards.

    The standards, desk review, and on-site audits ensure that only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, are included in the facility's uniform cost report and that the expense items included are accurately determined and are reasonable.

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30fhto verify that the facility has complied with paragraphs 2 and 3 above in Section A.

3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further auditing of the facility's financial and statistical records and other documents will be conducted as needed.

4. On-site audits of the financial and statistical records will be performed annually in at least 15 percent of participating facilities. Such on-site audits of financial and statistical records will be sufficiently

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comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.

5. The on-site audits conducted in accordance with Section B, paragraph 4 above shall produce an audit report which shall meet generally accepted auditing standards. The report shall declare the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.

6. Any overpayments found in audits under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

C. Allowability of Costs

The Department uses the Health Care Financing Administration Manual (HCFA-15-
1), Medicare principles, as a guide to determine allowable and non-allowable costs. However, in situations where warranted, the Department has developed policy regarding cost allowability outside of HCFA-15-1. In addition to the use of HCFA-15-1 as a guide, the Department describes specific cost allowability in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000, which is included as an attachment. The following paragraphs offer a general discussion of allowability of costs.

1. Allowable Costs Include the Following:

a) The cost of meeting certification standards. These costs include all items of expense which providers must incur to meet the definition of nursing facilities under Title XIX statutory and regulatory requirements and as otherwise prescribed by the Secretary of HHS for nursing facilities; in order to comply with requirements of the State Agency responsible for establishing and maintaining health standards; and in order to comply with any other requirements for nursing facility licensing under the State law;

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b) All items of expense which providers incur in the provision of routine services. Routine services include the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Additional allowable costs include depreciation, interest, and rent expense as defined in the principles of reimbursement in HFCA-15-1, except that actual malpractice insurance costs are reimbursed as reported in the facility's cost report, subject to audit verification; and

c) Costs applicable to services, facilities, and supplies furnished to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Providers are required to identify such related organizations and costs on the State's uniform cost report.

2. Non-Allowable Costs Include the Following:

a) Bad debts of non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs. The only bad debts allowable are those defined in 42 CFR 4 13.80. The value of operating rights and licenses and/or goodwill is not an – allowable cost and is not included in the computation of the return on equity;

b) Effective for the determination of reasonable costs used in the establishment of reimbursement rates on and after April 1, 1991, the costs listed below are nonallowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
- Memberships in civic organizations;

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- Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

- Fifty percent (50%) of membership dues for national, state and local associations;

- Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fund raising purposes; (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation; (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying; and

- The cost of home office vehicle expense.

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D. Methods and Standards for Determining Reasonable Cost-Related Payments

1. Nursing Facility and ICF/MR Methods and Standards

The methods and standards for the determination of reimbursement rates to nursing facilities, and intermediate care facilities for the mentally retarded is as described in Chapter 1000 of the Policies and Procedures for Nursing Facility Services manual which is included as an attachment.

2. Rates Take Into Account Economic Trends

Payment methods and standards utilized to establish prospective rates will reasonably take into account economic conditions and trends during the time period covered by the rates through the application of a growth allowance factor to historical costs. Effective July 1, 1999, the basis of nursing facility rates is the 1998 cost report with a growth allowance of 6.2%. The 6.2% growth allowance is based on the inflation factor contained in the publication titled DRI McGraw-Hill Health Care Costs for nursing facilities adjusted for the time delay between the reporting period and the reimbursement period. The cost report period and growth allowance may be updated periodically.

3. Prospective Rates

Payment rates to nursing facilities and ICF/MR's are determined prospectively using costs for a base period.

4. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of the Policies and Procedures for Nursing Facility Services manual.

5. Prospective Rates For Facilities with Service Deficiencies

The State does not adjust rates based on service deficiencies or quality of service.

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6. Additional Details

Detailed information regarding this methodology is maintained on file in the State Agency as Chapter 1000 of the Policies and Procedures for Nursing Facility Services manual, included as an attachment.

E. Payment Assurances

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

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

F. Provider Participation

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

G. Payment in Full

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

H. Payment Limitation Applicable to Patients in Nursing Facilities with Medicare Part A Entitlement

Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of services of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

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Daily cost-sharing charges for beneficiaries will commence on the 21st day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

I. Nurse Aide Training

The Department adjusts per diem payment rates to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment does not apply to ICF/MR facilities. Beginning with dates of service July 1, 1992, and after, the Department will not adjust reimbursement rates for the cost of replacement wages and overtime for nurse aide training and testing because these costs are included in the 1991 cost reports.

J. Public Process

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

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PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. General

This chapter provides an explanation of the Division's reimbursement methodology.

1002. Reimbursement Methodology

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in this chapter. In addition, it is subject to retroactive adjustment according to the relevant provisions of Chapter 400 and Section 504 of Part I of this manual.

1002.1 Definitions

a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Department of Family and Children Services (DFCS). Refer to the Billing Manual for Nursing Facility Services for information about the Summary Notification letter. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined in Sections 1002.2 and 1002.3.

c. A nursing facility is an institution licensed and regulated to provide skilled care, intermediate care, or intermediate care services for the mentally retarded in accordance with the provisions of this Manual. For reimbursement purposes, nursing facilities including hospital based facilities are

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divided into two types based upon the mix of Medicaid patients residing in the facilities. The type classification of a nursing facility may change as described in this chapter. The types are described below:

1. Nursing Facilities - These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital

2. Intermediate Care Facilities for the Mentally Retarded (ICF-MR) - These facilities provide care to patients that are mentally retarded.

d. Cost Center refers to one of five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special Services (Lines 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plant (Lines 109 and 123), Administrative and General (Line 169), and Property and Related (Line186). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.

e. Distinct Part Nursing Facilities are facilities in which a portion operates as a nursing facility and another portion operates separately as an intermediate care facility for the mentally retarded.

f. Total Patient Days are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.

g. Hospital-Based Nursing Facilities - A nursing facility is hospital-based when the following conditions are met:

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1) The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.

2) The facility is subordinate to the hospital and operated as a separate and distinct hospital division that has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.

3) The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of the hospital, must be responsible to the hospital's governing board.

4) The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

a) employee benefits
b) central services and supply
c) dietary
d) housekeeping
e) laundry and linen
f) maintenance and repairs

Section B

a) accounting
b) admissions
c) collections
d) data processing
e) maintenance of personnel

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Facilities must provide organizational evidence demonstrating that the above requirements of 4) have been met. This evidence will be used to determine which facilities will be hospital-based.

Evidence that the required number of services in Sections A and B are shared with the hospital must be included in the hospital's Medicare cost report.

Appropriate costs should be allocated to the nursing home and the Medicare cost report must be approved by the Medicare intermediary.

In making the determination that a long-term care facility is hospital-based, collocation is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents.

The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

(A) Only one hospital-based nursing facility per hospital is allowed.

(B) Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed Medicare cost report is used to file the Medicaid cost report to set a per diem rate.

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Nursing facilities classified as hospital-based prior to July 1, 1994, will be exempt from the above additional requirements. Hospitals, which currently have more than one hospital-based nursing facility, will not be allowed to include any additional hospital-based facilities.

h. Property Transaction is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger). For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all of the following events that are applicable to the transaction:

1. The effective date of the sale or the lease.

2. The first day a patient resides in the facility.

3. The date of the written approval by the Division of Health Planning of the relevant proposal.

4. The effective date of licensing by the Georgia Department of Human Resources Standards and Licensure Unit.

5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

6. The date on which physical construction is certified complete by whichever agency(ies) is/are responsible for this determination.

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7. The date of the approval of a Certificate of Need by the Division of Health Planning.

i. Gross Square Footage is the outside measurement of everything under a roof, which is heated and enclosed. When the Division issues the provider a rate under the Dodge Index Property System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of a facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.

j. Age is the original date a building was completed counted by years through December, 1983 with no partial year calculations. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and non-allowable costs is contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in CMS-15-1, the costs listed below are non-allowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
- Memberships in civic organizations;

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- Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable. For purposes of this provision, patient care staff includes only those who are transported in order to provide direct medical care to an individual patient.

- Fifty percent (50%) of membership dues for national, state, and local associations;

- Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fundraising purposes, (b) incurred in the sale or lease of a

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outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fundraising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement, or (e) related to government relations or lobbying.

- Funds expended for personal purchases.

1002.2 Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate

For dates of service beginning July 1, 2006, the 2005 Cost Report is the basis for reimbursement.

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem + Efficiency Per Diem + Growth Allowance + Other Rate Adjustments

Allowed Per Diem =

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available) for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center. The method by which a

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case mix index score is calculated is presented in the section of titled "Case Mix Index Reports." The case mix adjustment is made on a quarterly basis using data from the most recent quarterly period for which data are available. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

Efficiency Per Diem =

Summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers.

Growth Allowance =

Summation of 0.0% of the Allowed Per Diem for each of the four Non-Property and Related cost centers.

Further explanation of these terms is included below:

a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

   All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs by the Nursing Facilities Manual, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; or other parameters placed on reasonable cost by the Division. These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses that are attributable to care. See Appeals Section of this Manual for appellate procedures to resolve disputes of specific

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Allowable Home Office salary costs are limited to an appropriate maximum. Fringe benefits are also limited to an appropriate maximum. (A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a $100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of $100,000 to be applied only to owners of nursing facilities and related parties.) Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

Routine and Special Services Net Per Diem =

Nursing Facilities Net Per Diem =

(Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 6); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified in section 1002.2. The method by which a case mix index score is calculated is presented in the section of titled "Case Mix Index Reports."

ICF-MR Net Per Diem =

(Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 7).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs.

Dietary Net Per Diem =

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Historical Dietary, Schedule B, Line 8, Column 4, Divided By Total Patient Days

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of Plant, Schedule B, Lines 9 plus 10, Column 4, Divided By Total Patient Days

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B, Line 11, Column 4, Divided By Total Patient Days

Property and Related Net Per Diem =

For a facility with a Property and Related Net Per Diem in excess of the Property and Related Standard Per Diem, the Net Per Diem will be reduced to the Standard Per Diem. For any facility having a property transaction after May 6, 1981, (excluding leases for which the Division had approved rates on or before that date) the total Property and Related Net Per Diem, shall not exceed the Standard Per Diem.

Costs for property taxes and property insurance, as defined in the Uniform Chart of Accounts, are included but are not subject to the property and related cost center Standard Per Diem.

Historical Property & Related, Schedule B, Line 12, Column 4, Divided By Total Patient Days

The Return on Equity Percent is 0% for all facilities.

Facilities reimbursed as of June 30, 1994, and June 30, 1995, for actual arm's length property and related costs will be reimbursed at the Dodge Index rate if a change in the audited reimbursement rate results in a per diem increase.

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Facilities reimbursed as of June 30, 1994, and June 30, 1995, at actual arm's length property and related costs including those subject to standards, will not be reimbursed at the Dodge Index rate if a change in audited reimbursement results in a per diem decrease, unless a property transaction occurs as described in Section 1002.5(a) in which case the Dodge Index will apply. Until the Dodge Index applies to these facilities, reimbursement will continue at actual arm's length property and related costs.

Facilities reimbursed for actual property and related costs will be reimbursed at the Dodge Index rate as described in Section 1002.5(a) through (f) below, if actual property and related costs per diem become less than the Dodge Index rate or if there is a property transaction according to Section 1002.5(a).

Facilities reimbursed at the Dodge Index rate will remain at Dodge Index rate for all subsequent periods.

b. Standard Per Diem for each of the five cost centers is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be multiplied by the Maximum Percentile, or a median net per diem may be chosen, with the Maximum Cost per day being determined as a percentage of the median. The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for efficiency incentive payments is 105% of the median cost per day within each peer group. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, the sixtieth percentile for Dietary, the eighty-fifth percentile for the Laundry and Housekeeping and Operation and Maintenance of Plant cost centers, and the ninetieth percentile for Property and Related cost centers. If the Maximum Percentile does not correspond to a

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specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation.

The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division on June 30, 2003. Standards effective July 1, 2003, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center.

There are several instances where a facility could fall in more than one group. Intermediate care facilities for the mentally retarded which also are nursing facilities are classified as intermediate care facilities for the mentally retarded.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility it is as of June 30, 2003.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Dietary Standard Per Diem

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For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped by the age of the facility as follows:

All facilities constructed five or less than five years ago

All facilities constructed ten or less than ten years ago, but more than five years ago

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All facilities constructed more than ten years ago

For purposes of this standard per diem, the age of the facilities as of October 1976 will be used. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the five cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero ($0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by .75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums:

Routine and Special Services Maximum Efficiency Payment	$0.53
Dietary Maximum Efficiency Payment	$0.22
Laundry and Housekeeping and Operation and Maintenance of Plant Maximum Efficiency Payment	$0.41
Administrative and General Maximum Efficiency Payment	$0.37
Property and Related Maximum Efficiency Payment	$0.40

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1002.3 Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

If the Division determines that a cost report cannot be used to set a billing rate the per diem rate will be established, as follows:

a) When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Appendix D2(h).)

b) Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.

c) In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports.

The Total Allowed Per Diem Billing Rate for homes with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to either the Dodge Index Rate as determined under Section 1002.5(a) through (g), or the lesser of projected costs or the maximum allowable costs as determined by Section 1002.5(a) divided by that number of patient days which represents a 95% rate of occupancy.

TN No. 05-009
Supersedes
TN No. 03-009
Approval Date: 05/17/06
Effective Date: 07/01/05

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d) In all other instances where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports. If the Division determines that a cost report which was to be used to set a reimbursement rate is unauditable (i.e., the Division's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk audit or on-site audit), or unreliable (See Appendix D2(h).), the Division may reimburse the facility the lower of the following:

- The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditable cost report;
- The Total Allowed Per Diem Billing Rate calculated from the unauditable cost report; or
- The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

Effective April 1, 1982, the Property and Related cost center reimbursement for those facilities whose cost reimbursement is limited to the Standard (90th percentile) Per Diem in this cost center will be based upon the Standard Per Diem calculated from the cost reports for the year ending June 30, 1981.

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e) If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department will use the average score for all facilities.

1002.4 Other Rate Adjustments

A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services will be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1. The Division will also require that a facility participate in Division-sponsored quality improvement initiatives in order to receive this adjustment.

For the most recent calendar quarter for which MDS information is available, Cognitive Performance Scale (CPS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor will be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose CPS scores are moderately severe to very severe. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	4.5%

Effective July 1, 2003, in order to recognize the Medicaid share of a facility's cost of paying fees for Georgia's the Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to a facility's rate. During the quarter beginning July 1, 2003, the adjustment amount will be estimated by the Division; any difference between the estimated

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and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.

1002.5 Property and Related Reimbursement Limitations

The Division has established additional criteria to determine the reasonableness of property and related costs.

Property Transactions after June 14, 1983

a. For any facility having a property transaction, including a renewal of a lease, with an effective date after June 14, 1983, excluding additions, expansions and renovations, the steps described in paragraphs (b) through (f) of this subsection comprise the Dodge Index method of property and related reimbursement which will be performed to set the property and related net per diem for a facility. Facilities reimbursed for actual property and related costs will be reimbursed at the Dodge Index rate if actual property and related costs per diem become less than the Dodge Index rate or if there is a property transaction according to this section. Facilities reimbursed at the Dodge Index rate will remain at the Dodge Index rate for all subsequent periods. This will be referred to as the property rate component for the remainder of this subsection. The property rate component is then used in the computation of a facility's Allowed Per Diem as defined in Sections 1002.2 and 1002.3.

The Division does not recognize the termination of a lease prior to its stated expiration date as a property transaction. It will be presumed that the termination of a lease prior to its stated expiration date was done to increase Medicaid reimbursement; provided, however, that the presumption is rebuttable if the provider can demonstrate by clear and convincing evidence that the lease was terminated for some other legitimate purpose. In the event of the termination of

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a lease prior to its stated expiration date, the facility's Property and Related reimbursement rate will then be based upon historical costs or the Dodge Index Rate, whichever applies.

b. The property rate component is comprised of four sub-components:

(i) Building and Building Equipment

(ii) Major and Minor Moveable Equipment

(iii) Motor Vehicle Equipment

(iv) Land

The method of calculating the rate for each of these sub-components is described in the following paragraphs.

c. The Building and Building Equipment sub-component is calculated by dividing the reasonable construction acquisition cost by total patient days.

Reasonable construction acquisition cost is determined as follows:

i) For all existing facilities, multiply the regional Dodge Construction Index from the April - September, 1982 issue for the calendar year preceding the prospective rate year by the average construction multiplier for Atlanta. For facilities less than 30,000 square feet the cost range of 20,000 - 30,000 square feet will be used and for facilities 30,000 square feet or greater the cost range will be based on the 30,000 - 40,000 square foot indicator. All facilities having their first property transaction after June 14, 1983 (i.e., newly constructed

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facilities) will use the 30,000 - 40,000 square foot range.

ii) Multiply the product from (i) by 108%.

iii) Multiply the product from (ii) by the gross square footage of the facility with a maximum of 300 square feet per bed allowed. (New facilities will use 300 square feet per bed regardless of actual square footage. Existing facilities will use actual footage up to the maximum allowable. New facilities for which a subsequent property transaction occurs will use actual square footage up to the maximum

iv) Multiply the result of (iii) by the depreciation factor. The depreciation factor is calculated by subtracting the age of the facility in years from 40 and dividing the result by 40. Where the facility is more than 20 years old, a value of 20 is used such that the facility is never more than 50% depreciated based on a 40 year life.

v) Multiply the result of (iv) by an amortization factor which is determined according to the formula below:

1 / (1/r x [1-1/(1+r)n])

r represents the return rate and n is the remaining years of life of the facility based on a 40 year life.

Total Patient Days equals 90% of the maximum number of available patient days for a given facility per year.

For facilities having their property transaction after June 14, 1983 (i.e., newly constructed facilities), the building and building equipment component will be determined in accordance with the effective date of

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that property transaction as defined in Section 1002.1(h). The regional Dodge Construction Index from April-September of the calendar year preceding the property transaction will be used to determine a building rate component. The return rate for Dodge Index facilities is 11%.

Return Rate - This percentage will be reviewed and set by the Division.

d. The Division will calculate a Moveable Equipment (major and minor) cost per bed at current replacement cost. For 1983 the value has been set at $1,600.00 per bed.

Effective April 1, 1990, this Moveable Equipment value was increased to $2176.00 per bed and effective July 1, 1993, will be increased to $2430.00 per bed. A composite life of twelve years will be used to compute the amortization factor. The major and minor moveable equipment sub-component is calculated by multiplying the cost per bed by the amortization factor and dividing the product by total patient days. The current replacement cost will be reviewed by the Division of Medical Assistance and may be indexed utilizing the medical equipment price index published by the Centers for Medicare and Medicaid Services or another appropriate proxy for moveable equipment cost.

e. The Division will calculate a reasonable allowance for Motor Vehicle Equipment. For 1983, the value has been set at $8,000.00 per 100 beds or fraction thereof. A life of four years will be used to compute the amortization factor. The motor vehicle equipment sub-component as calculated by multiplying the reasonable allowance by the amortization factor and dividing the product by total patient days.

The reasonable allowance will be reviewed by the Division and may be indexed utilizing the transportation component

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of the Consumer Price Index or another appropriate proxy for motor vehicle equipment cost.

f. In calculating the Land sub-component, acreage will be screened for cost reasonableness and limited to the lower of actual acres or the maximum established for the facility. The maximum varies according to the number of beds and facility location (rural or urban).

For a facility in an urban area (i.e., a Metropolitan Statistical Area-MSA-county), land is limited to three acres for a 100 bed home plus one acre for each additional 100 beds or fraction thereof. The maximum cost allowed per acre is $70,800. For any provider which applies for an adjustment to its Property and Related Net Per Diem on or after April 1, 1987, due in any part to costs associated with the acquisition of land (including, but not limited to purchases and leases), such land acquisition costs shall be allowable only to the extent that they do not exceed $70,800 per acre. In a rural area (non-MSA), land is limited to five acres for a 100 bed home plus one acre for each additional 100 beds or fraction thereof. The maximum cost allowed per acre is $42,480. For any provider which applies for an adjustment to its Property Related Net Per Diem on or after April 1, 1987, due in any part to costs associated with the acquisition of land (including, but not limited to, purchases and leases), such land acquisition costs shall be allowable only to the extent that they do not exceed $42,480 per acre.

Reimbursement for additional land for facilities in urban and rural locations will be allowed to meet requirements such as local codes for sewage disposal, parking, and density.

Original land cost should be documented by original accounting records, county records, or an acceptable reasonable basis such as an allocation procedure. If the

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original land cost cannot be properly documented, no allowed rate will be calculated.

(i) To calculate the rate for facilities with land areas exceeding the maximum allowable:

(a) Divide the allowable original land acquisition cost by the total acreage.

(b) Multiply the average acquisition cost per acre by the maximum allowable land areas as determined by the rules outlined above.

(c) Multiply the result in (i)(b) by the return rate.

(d) Divide the result from (i)(c) by the number of patient days.

(ii) To calculate the rate for facilities with land areas at or below the maximum allowable:

(a) Multiply the allowable land and acquisition cost by the return rate.

(b) Divide the result from 2(ii) by the number of patient days.

The property rate component will be set at the sum of the building and building equipment, moveable equipment, motor vehicle equipment and land rate subcomponents.

g. For any facility having an Initial Transaction after July 13, 1978, and which has a subsequent transaction on or after June 15, 1983, by the same party, a related party, or a different operator within ten years after the initial transaction, reimbursement is defined in subparagraphs (i) and (ii) below.

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(i) During the ten years following an initial transaction prior to June 15, 1983, reimbursement will be the lesser of:

(a) reported costs of the subsequent transaction (the most recent lease, sale or change of ownership occurring within 10 years of the initial transaction),

(b) the Standard Per Diem, if the initial transaction occurred after May 6, 1981, but before June 15, 1983, or

(c) costs as determined by paragraphs (b) through (f) as the date of the lease, sale, or change of ownership that gave rise to the application of this paragraph.

(ii) During the ten years following an initial transaction after June 14, 1983, reimbursement will be the lesser of:

a) costs as determined by paragraphs (b) through (f) at the date of the initial transaction, or

(b) costs as determined by paragraphs (b) through (f) at the date of the subsequent transaction.

h. For a facility having an addition, expansion, or renovation after June 14, 1983, reimbursement will be determined as follows:

(i) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement will not be increased as the result of

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renovation unless all of the following conditions are satisfied:

- the renovation is mandated by state or federal law as implemented through policies and procedures of the Georgia Department of Human Resources Standards and Licensure Unit

- the additional reimbursement is determined by a replacement cost appraisal (however, at the Division's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).

- the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable diligence will include but is not limited to obtaining an inspection and its resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

(ii) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement for additions and expansions will be subject to limitations described in paragraphs (b) through (f). If the addition or expansion does not

add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate sub-component for the addition.

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.7 Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

1002.8 Adjustments to Rates

Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

1003. Additional Care Services

1003.1 Required Nursing Hours

The minimum required number of nursing hours per patient day for all nursing facilities is 2.50 actual working hours.

1003.2 Failure to Comply

a) The minimum standard for nursing hours is 2.50.
b) Facilities found not in compliance with the 2.50 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary

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penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.

1004. Medicare Crossover Claims

The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

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APPENDIX D

UNIFORM CHART OF ACCOUNTS, COST REPORTING, REIMBURSEMENT PRINCIPLES AND OTHER REPORTING REQUIREMENTS

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing facilities participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its

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accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)

b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of $50.00 per day for the first thirty days and a penalty of $100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Division Director of Nursing Home Reimbursement Services prior to September 30.

c. If a cost report is received by the Division prior to September30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above

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described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.

d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

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f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.

h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Dodge Index property rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates,

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the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.

k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate workpapers or letters of explanation should be attached.

l. All cost reports and correspondence concerning these cost reports are to be mailed to the following address:

Division of Medical Assistance
Nursing Home Services Unit
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

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3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.

b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.

c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated

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payer source information for changes that may occur by the last day of the calendar quarter.

d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.

e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.

f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.

g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments will be processed as adjustments to rate calculations in a subsequent period. If a prospective correction would otherwise result in excess or advance payments of material amounts, with materiality determined by the amount or percentage of payment, the Division will process the correction by a retrospective adjustment to prior payments.

A detailed description of all data elements in the Case Mix Index Report is presented in Exhibit D-2.

5. Nursing Hours and Patient Day Report

Except for ICF-MR and state owned facilities, each facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within

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one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

If a facility does not submit a report or does not submit a report when due, a late fee of $10 per day may be assessed.

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EXHIBIT D-1

	Category	Classification	**Code**	**Case Mix Index for All Patients**	**Case Mix Index for Medicaid Patients**
1	Extensive	Extensive Special Care 3 / ADL >6	SE3	2.839	2.896
2	Extensive	Extensive Special Care 2 / ADL >6	SE2	2.316	2.362
3	Rehabilitation	Rehabilitation All Levels / ADL 17-18	RAD	2.284	2.330
4	Extensive	Extensive Special Care 1 / ADL >6	SE1	1.943	1.982
5	Rehabilitation	Rehabilitation All Levels / ADL 14-16	RAC	1.936	1.975
6	Special Care	Special Care / ADL 17-18	SSC	1.877	1.915
7	Rehabilitation	Rehabilitation All Levels / ADL 9-13	RAB	1.772	1.807
8	Special Care	Special Care / ADL 15-16	SSB	1.736	1.771
9	Special Care	Special Care / ADL 4-14	SSA	1.709	1.743
10	Rehabilitation	Rehabilitation All Levels / ADL 4-8	RAA	1.472	1.501
11	Clinically Complex	Clinically Complex with Depression / ADL 17-18	CC2	1.425	1.454
12	Clinically Complex	Clinically Complex / ADL 17-18	CC1	1.311	1.337
13	Clinically Complex	Clinically Complex with Depression / ADL 12-16	CB2	1.247	1.272
14	Physical	Physical Function with Nursing Rehab / ADL 16-18	PE2	1.188	1.212
15	Clinically Complex	Clinically Complex / ADL 12-16	CB1	1.154	1.177
16	Physical	Physical Function with Nursing Rehab / ADL 11-15	PD2	1.095	1.117
17	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 6-10	IB2	1.061	1.082
18	Clinically Complex	Clinically Complex with Depression / ADL 4-11	CA2	1.043	1.064
19	Physical	Reduced Physical Function / ADL 16-18	PE1	1.077	1.077
20	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 6-10	BB2	1.021	1.041
21	Physical	Reduced Physical Function / ADL 11-15	PD1	0.990	0.990

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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
22	Impaired Cognition	Cognitive Impairment / ADL 6-10	IB1	0.938	0.957
23	Physical	Physical Function with Nursing Rehab / ADL 9-10	PC2	0.937	0.956
24	Clinically Complex	Clinically Complex / ADL 4-11	CA1	0.934	0.953
25	Behavioral Problems	Behavior Problem / ADL 6-10	BB1	0.866	0.883
26	Physical	Physical Function with Nursing Rehab / ADL 6-8	PB2	0.824	0.841
27	Physical	Reduced Physical Function / ADL 9-10	PC1	0.865	0.865
28	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 4-5	IA2	0.777	0.777
29	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 4-5	BA2	0.750	0.750
30	Physical	Reduced Physical Function / ADL 6-8	PB1	0.749	0.749
31	Impaired Cognition	Cognitive Impairment / ADL 4-5	IA1	0.703	0.703
32	Physical	Physical Function with Nursing Rehab / ADL 4-5	PA2	0.637	0.637
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

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Exhibit D-2
Detailed Description of Data Presented in Case Mix Index Reports

Selection criteria for quarterly "Listing of Residents" reports – Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged, and these individuals are not included in this report. The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

AA8a, b – Reasons for assessment as reported in section AA8 of the MDS

Section a, primary reason for assessment
1 =admission assessment
2 =annual assessment
3 =significant change in status assessment
4 =significant correction of prior full assessment
5 =quarterly review assessment
6 =discharged – return not anticipated
7 =discharged – return anticipated
8 =discharged prior to completing initial assessment
9 =reentry
10 =significant correction of prior quarterly assessment
0 =none of the above

Section b, codes for assessments required for Medicare PPS or the State
1 =Medicare 5 day assessment
2 =Medicare 30 day assessment
3 =Medicare 60 day assessment
4 =Medicare 90 day assessment
5 =Medicare readmission/return assessment
6 =other state required assessment
7 =Medicare 14 day assessment
8 =other Medicare required assessment

Resident Name – Self explanatory

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SSN- Resident's social security number

Effective Date (R2b) – For assessments, this is the date completed as reported in section R2b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

Classification Code – RUG classification code (see "Case Mix Index for All Patients" in Exhibit D-1) from application of 34 grouper with index maximizing

Classification Category – Description of RUG classification (see Exhibit D-1)

Resident ID – Identification number assigned to resident by MDS reporting system

CPS Score – 5 MDS measures (related to coma, decision-making, impairment count, severe impairment count and total dependent eating) are used to classify a resident's condition into one of the following Cognitive Performance Scale categories: intact, borderline impairment, mild impairment, moderate impairment, moderately severe impairment, severe impairment or very severe impairment.

Payment Source – Primary source of payment for services to resident based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as "other." A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.

Number of Residents, Overall CMI Averages and Medicaid CMI Average – The number of residents and average case mix index score, based on relative weights for "Case Mix Index for All Patients" in Exhibit D-1, are listed for 3 categories of residents by payment source – Medicaid, Medicare and Other. For Medicaid patients, an average case mix index score, based on relative weights for "Case Mix Index for Medicaid Patients," is also listed.

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Number and % of Residents Included in CPS Add-On – The number and percentage of Medicaid residents with CPS classifications of moderately severe impairment, severe impairment or very severe impairment

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For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- All amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

A sample of how a rate adjustment payment is calculated is presented on the following pages.

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	Provider Name:	XYZ Nursing Home			
		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
Medicare UPL Rate					
Line 1	PPS rate based on Medicaid patients for each quarter [1]	157.92	149.92	149.92	149.92
Line 2	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
Line 3	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
Medicaid UPL Rate					
Line 4	Medicaid rate without provider fee [1]	89.63	86.90	85.63	90.69
Line 5	Provider Fee adjustment	9.15	9.15	9.15	9.15
Line 6	Statewide average payment for other services [1]	14.11	14.11	14.11	14.11
Line 7	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
Medicare UPL rate minus Medicaid UPL rate					
Line 8		47.40	42.01	43.28	38.22
Medicaid Patient Days					
Line 9	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
Line 10	Portion of year for each quarter	25%	25%	25%	25%
Line 11	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
Facility-Specific UPL calculation					
Line 12		261,032	231,349	238,343	210,478
Facility-Specific UPL calculation for 7-1-05 to 06-30-06					941,202

[1] Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.

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facility name XYZ ICF-MR Nursing Home

	line description	comments	amount
1	total cost per day for SFY2004	after audit adjustments	267.70
2	capital cost per day for SFY2004	after audit adjustments	9.44
3	routine services cost per day for SFY2004	col 1 - col 2	258.26
4	projected routine service cost per day for SFY2006	col 3 x 1.06181	274.22
5	12% of projected routine service cost per day for SFY2006	col 4 x 0.12	32.91
6	Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415
7	available UPL calculation for SFY2006	col 5 x col 6	968,048

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