12 VAC 30-90-19.

Subject to legislative authorization as required and the availability of local, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS makes additional payments to local government nursing facilities. A local government nursing facility is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority or commission.

DMAS uses the following methodology to calculate the additional Medicaid payments to local government nursing facilities:

1) For each State Fiscal Year, DMAS calculates the maximum additional payments that it can make to the local government nursing facilities in conformance with 42 CFR 447.272 (a).

2) DMAS determines a total additional payment amount to be made in a manner not to exceed the maximum additional payment amount calculated in step 1 above.

3) Using the latest fiscal period for which the local government nursing facilities have completed cost reports on file with DMAS, the Department determines the total Medicaid days reported by each local government nursing facility for that fiscal period.

4) DMAS divides the total Medicaid days for each local government nursing facility by the total Medicaid days for all local government nursing facilities to determine the supplementation factor for each.

5) For each local government nursing facility, the Department multiplies the local government nursing facility's supplementation factor determined in step 4 above by the total additional payment amount identified in step 2 above to determine the additional payment to be made to each local government nursing facility.

CERTIFIED:

_____ _____

Date C. Mack Brankley, Acting Director
Dept. of Medical Assistance Services

Part II

Nursing Home Payment System

Subpart I

General

12VAC30-90-20. Nursing home payment system; generally.

A. Effective ~~October 1, 1990~~, July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part. ~~The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those nursing facilities operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.~~

B. Three separate cost components are used: plant or capital, as appropriate, cost[– ;] operating cost [;] and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2001, in ~~In~~ determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established

for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds ~~and~~ in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A nursing facility located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in [~~12 VAC 30-90-35~~ Articles 1 and 3], [~~12VAC30-90-40~~ Article 4], [~~12VAC30-90-60~~ Article 6], and [~~12VAC30-90-80~~ Article 8], as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare ~~and Medicaid~~ principles of reimbursement and Medicaid principles of reimbursement in effect on June 30, 2000, except that those that are defined as skilled nursing facilities (SNFs) and are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270) and must be identifiable and ~~verified~~ verifiable by contemporaneous documentation. All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

12 VAC 30-90-21 through 12 VAC 30-90-28. Reserved.

Subpart II

Rate Determination Procedures

Article 1. Transition to new capital payment methodology.

12 VAC 30-90-29.

A. This section provides for a transition to a new capital payment methodology. The methodology that will be phased out for most facilities is described in Article 2. The methodology that will be phased in for most facilities is described in Article 3. The terms and timing of the transition are described in this article.

B. Transition Policy. Nursing facilities enrolled in the Medicaid program prior to July 1, 2000 shall be paid for capital related costs under a transition policy from July 1, 2000 through June 30, 2012. Facilities and beds paid under the transition policy shall receive payments as follows:

1. During SFY2001, each facility's capital per diem shall be the facility's capital per diem on June 30, 2000. The methodology under which this per diem is determined shall be the plant cost reimbursement methodology in effect as of June 30, 2000.

2. During SFY 2002, each facility subject to the transition policy shall be paid for capital costs under the methodology described in Article 2.

3. During SFY 2003 through SFY 2012, each facility subject to the transition policy shall have a capital per diem that is a percentage of the per diem described in Article 2 plus a percentage of the per diem described in Article 3. The percentage associated with the per diem described in Article 2 shall be 90% for services provided in SFY 2003, 80% for services in SFY 2004, 70% for services in SFY 2005, and so on until the percentage is 0% for services in SFY 2012. The percentage associated with the per diem described in Article 3 shall be equal to 100% minus the percentage associated with the per diem

described in Article 2. In SFY 2012, the capital per diem shall be based entirely on the per diem described in Article 3.

C. [~~Effective July 1, 2001, there shall no longer be a payment for return on equity for leased nursing facilities~~. Return on equity (ROE) for leased facilities shall be phased out along with the methodology described in Article 2. Leased facilities shall be eligible for ROE after July 1, 2001, only if they were receiving ROE on June 30, 2000.]

D. Beds Excluded from the Transition Policy. Effective July 1, 2001 newly constructed facilities and new and replacement beds of previously enrolled facilities, completed after July 1, 2000, shall be paid entirely under the methodology described in Article 3 without application of the transition policy. However, facilities and beds with COPN applications submitted as of June 30, 2000, shall be subject to the transition policy. Facilities changing ownership after June 30, 2000, [~~shall be paid, during the transition period, the lesser of the per diem described in Article 3 or the transition policy payment. An exception to the policy provided in this subsection shall be made for facilities changing ownership after June 30, 2000, if they are not part of a chain organization or if they are part of a chain organization consisting of no more than two facilities. The exception is that beginning July 1, 2002, facilities meeting this criterion shall be paid the per diem described in Article 3.~~ if the facility being sold is not part of a chain organization, or if it

is part of a chain organization consisting of no more than two facilities, shall be paid the per diem rate described in Article 3.] [For purposes of this provision, the number of facilities in a chain shall be determined by counting nursing facilities, hospitals, and any other health care facilities that are licensed to admit patients or residents, whether or not they participate in the Medicaid program. Facilities in Virginia and in other states shall be counted in determining the number of facilities in a chain. Facilities shall be considered to form a chain if there is common ownership of the physical assets, or a common operator, or both.]

E. Emergency regulations effective July 1, 2000, provided for a facility specific fixed capital per diem applicable to services in SFY 2001, that is not to be adjusted at settlement. After SFY 2001, the per diem that would have been applicable to SFY 2001, under the methodology in Article 2 shall be calculated. If there are two provider fiscal years that overlap SFY 2001, this per diem shall be a combination of the two applicable per diem amounts. If the per diem provided in the emergency regulations is lower than the per diem based on Article 2, the difference, multiplied by the days in SFY 2001, shall be paid to the facility. If the per diem provided in the emergency regulations is higher, the difference, multiplied by the days, shall be collected from the facility in the settlement of the provider year settled after the difference is calculated.

Article ~~1~~ 2

Plant Cost Component

12VAC30-90-30. Plant cost.

A. This Article describes a capital payment methodology that will be phased out for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that will eventually replace this one for most facilities is described in Article 3.

~~A.~~ B. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

~~B.~~ C. ~~To~~ Effective July 1, 2001, to calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as ~~95%~~ 90% of the daily licensed bed complement during the applicable cost reporting period. [For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.]

~~C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.~~

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are non-reimbursable plant costs.

12VAC30-90-31. New nursing facilities and bed additions.

A. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see 12VAC30-90-51.)

B. Reimbursable costs for building and fixed equipment shall be based upon the ~~¾ (25% of the surveyed projects with costs above the median, 75% with costs below the median)~~ 75th percentile square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit, which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above ~~¾~~ 75th percentile square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction

cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data ~~¾~~ 75th percentile square foot costs for [~~nursing homes~~ NFs].

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued (see 12VAC5-220-10 et seq.).

12VAC30-90-32. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in 12VAC30-90-51) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating

any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see 12VAC30-90-51.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with 12VAC30-90-31 B.

12VAC30-90-33. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be

less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment

for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under 12VAC30-90-30 B and C, and 12VAC30-90-55 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with subdivisions A 1 through A 4 of this section for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

7. Balloon loan reimbursement. This subdivision applies to the construction and acquisition of nursing facilities (as defined in 12VAC30-90-31 and 12VAC30-90-34) and major capital expenditures (as defined in 12VAC30-90-32) that are financed with balloon loans. A balloon loan requires periodic payments to be made that do not fully amortize the principal balance over the term of the loan; the remaining balance must be repaid at the end of a specified time period. Demand notes and loans with call provisions shall not be deemed to be balloon loans.

a. Incurred interest. Reimbursement for interest of a balloon loan and subsequent re-financings shall be considered a variable interest rate loan under subsection B of this section.

(1) A standard amortization period of 27 years, from the inception date of the original balloon loan, must be computed by the provider and submitted to DMAS and used as the amortization period for loans for renovation, construction, or purchase of a nursing facility.

(2) A standard amortization period of 15 years, from the inception [date] of the original balloon loan, must be used as the amortization period for loans on furniture, fixtures, and equipment.

(3) A loan which is used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for the purpose of determining the amortization period.

b. The allowable interest rate shall be limited to the interest rate upper limit in effect on the date of the original balloon loan, unless another rate is allowable under subsection B of this section.

c. Financing costs. The limitations on financing costs set forth in subsection B of this section shall apply to balloon loans. Financing costs exceeding the limitations set forth in these sections shall be allowed to the extent that such excess financing costs may be offset by any available interest savings.

(1) A 27-year amortization period must be used for deferred financing costs associated with the construction or purchase of a nursing facility.

(2) A 15-year amortization period must be used for deferred financing costs associated with financing of furniture, fixtures, and movable equipment.

(3) Financing costs associated with a loan used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for determination of the amortization period.

d. Cumulative credit computation. The computation of allowable interest and financing costs for balloon loans shall be calculated using the following procedures:

(1) A standard amortization schedule of allowable costs based upon the upper limits for interest and financing costs shall be computed by the provider and submitted to DMAS for the applicable 27-year or 15-year periods on the original balloon loan.

(2) For each cost reporting period, the provider shall be allowed the lesser of loan costs (interest and financing costs) computed in accordance with subdivision 7.a. of this subsection, or the actual loan costs incurred during the period.

(3) To the extent that there is a "credit" created by the actual loan costs being less than the loan costs computed on the amortization schedule in some periods, the provider may recover any otherwise allowable costs which result from the refinancing, extension, or renewal of the balloon loan, and any loan costs which have been disallowed because the loan costs are over the limitation for some periods. However, the cumulative actual loan cost reimbursement may not exceed the cumulative allowable loan cost as computed on the amortization schedule to that date.

(4) In refinancing or refinancings of the original balloon loan which involve additional borrowings in excess of the balance due on the original balloon loan, the excess over the balance due on the balloon loan shall be treated as new debt subject to the DMAS financing policies and regulations. Any interest and financing costs incurred on the refinancing shall be allocated pro rata between the refinancing of the balloon loan and the new debt.

(5) In the event of a sale of the facility, any unused balance of cumulative credit or cumulative provider excess costs would follow the balloon loan or the refinancing of the balloon loan if the balloon loan or its refinancing is paid by the buyer under the same terms as previously paid by

the seller. Examples of this are (i) the buyer assumes the existing instrument containing the same rates and terms by the purchaser; or (ii) the balance of the balloon loan or its refinancings is financed by the seller to the buyer under the same rates and terms of the existing loan as part of the sale of the facility. If the loan is otherwise paid in full at any time and the facility is sold before the full 27-year or 15-year amortization period has expired, the balance of unused cumulative credit or cumulative provider excess costs shall expire and not be considered an allowable cost.

e. In accordance with subdivision A 5 of this section, no refinancing incentive shall be available for refinancings, extensions, or renewals of balloon loans.

f. The balloon loan and refinancing of the balloon loan shall be subject to all requirements for allowable borrowing, except as otherwise provided by this subsection.

B. Interest rate upper limit. Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative re-offering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2.a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-

year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in subdivisions 1 and 2 of this subsection shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in

effect on the date of commitment for construction financing or the date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the provider's interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or [~~his~~ its] actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in subdivisions 1, 2, and 3 of this subsection shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees

b. Guarantee Fees

c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)

d. Underwriters Discounts

e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with §2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

12VAC30-90-34. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider and must notify DMAS of the sale within 30 days of the date legal title passes to the purchaser. The notification [~~should~~ shall] include:

1. That a sale or transfer is about to be made or has already occurred;

2. The location and general description of the property;

3. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years;

B. The following reimbursement principles shall apply to the purchase of a NF:

~~1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Subpart XVI - Revaluation of Assets (12VAC30-90-260 et seq.). Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.~~

[~~2~~ 1.] [~~Notwithstanding the provisions of 12VAC30-90-51, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility~~ The allowable cost of a purchase of an existing nursing facility (whether or not the parties to the sale are, were, or will be providers of Medicaid services and whether or not the parties are related at the time of the sale) ~~shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.~~] [The allowable cost of a bona fide purchase of an existing nursing facility (whether or not the parties to the sale are, were, or will be providers of Medicaid services) shall be the seller's allowable depreciated historical cost (net book value) as determined for Medicaid reimbursement. The amount of allowable debt or borrowing to finance such a purchase shall be limited to the greater of the amount of the seller's net book value of the assets purchased, or the

seller's related allowable debt, both as determined for Medicaid reimbursement plus required financing costs limited in accordance with the provisions of 12 VAC 30-90-33 sections B.6. and B.7.]

~~3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See 12VAC30-90-51 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."~~

[2. For purposes of Medicaid reimbursement, a "bona fide" purchase shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See 12VAC30-90-51 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."]

[~~4~~ ~~2.~~ 3.] The useful life of the fixed assets of the facility shall be ~~determined by AHA guidelines~~.

~~5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed~~

~~upon by DMAS~~. the seller's remaining depreciable lives as determined for Medicaid reimbursement.

~~6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.~~

[~~3.~~ 4.] The seller must file a final cost report within 150 days of the date of sale.

~~C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.~~

~~D. At a minimum, appraisals must include a breakdown by cost category as follows:~~

~~1. Building; fixed equipment; movable equipment; land; land improvements.~~

2. ~~The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be included in the appraisal. This information shall be utilized to compute depreciation schedules.~~

~~E. Depreciation recapture.~~

~~1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there~~

~~is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).~~

~~2. No depreciation adjustment shall be made in the event of a loss or abandonment.~~

~~F. Reimbursable depreciation~~

~~1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.~~

~~2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.~~

~~3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:~~

~~a. That a sale or transfer is about to be made;~~

~~b. The location and general description of the property to be sold or transferred;~~

~~c. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years; and~~

~~d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.~~

~~4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.~~

~~5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.~~

~~6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.~~

~~7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.~~

~~8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.~~

~~An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.~~

Article 3

Fair Rental Value Capital Payment System

12VAC30-90-35. General applicability. This article describes a capital payment methodology that will be phased in for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that this one will replace for most facilities is described in Article 2.

12 VAC 30-90-36. Nursing Facility Capital Payment Methodology. Applicability. The capital payment methodology described in this article shall be applicable to freestanding nursing facilities but not to hospital based facilities. Hospital based facilities shall continue to be reimbursed under the methodology contained in Article 2. [For purposes of this provision a hospital based nursing facility shall be one for which a combined cost report is submitted on behalf of both the hospital and the nursing facility.]

Definitions. The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"Capital costs" means costs that include the cost elements of depreciation, interest, financing costs, rent and lease costs for property, building and equipment, property insurance and property taxes.

"Date of acquisition" means the date legal title passed to the buyer. If a legal titling date is not determinable for a nursing facility building, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

"Facility average age" means for a facility the weighted average of the ages of all capitalized assets of the facility, with the weights equal to the expenditures for those assets. The calculation of average age shall take into account land improvements, building and fixed equipment, and major movable equipment. The basis for the calculation of average age shall be the schedule of assets submitted annually to the Department in accordance with the provisions of this section.

"Facility imputed gross square feet" means a number that is determined by multiplying the facility's number of nursing facility licensed beds licensed by the Virginia Department of Health by the imputed number of gross square feet per bed. The imputed number of gross square feet per bed shall be 461 for facilities of 90 or fewer beds, and 438 for facilities of more than 90 beds. The number of licensed nursing facility beds shall be the number on the last day of the provider's most recent fiscal year end for which a cost report has been filed.

"Factor for land and soft costs" means a factor equaling 1.429 which adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility, that are not part of the [~~RSMeans~~ R.S. Means] construction cost amount.

"Fixed capital replacement value" means an amount equal to the [~~RSMeans~~ R.S. Means] 75th percentile nursing home construction cost per square foot, times the applicable [~~RSMeans~~ R.S. Means] historical cost index factor, times the factor for land and soft costs, times the applicable [~~RSMeans~~ R.S. Means] [~~location factor~~ "Location Factor"], times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 2.86% per year.

"Hospital based facility" means one for which a single combined [~~Medicaid~~ Medicare] cost report is filed that includes the costs of both the hospital and the nursing home.

"Movable capital replacement value" means a value equal to $3,475.00 per bed in SFY2001, and shall be increased each July 1st by the same [~~RSMeans~~ R.S. Means] historical cost index factor that is used to calculate the fixed capital replacement value. Each year's updated movable capital replacement value shall be used in the calculation of each provider's rate for the provider year beginning on or after the date the new value becomes effective.

"[~~RSMeans~~ R.S. Means] 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of the [~~RSMeans~~ R.S. Means] publication this value is $110, which is reported as a January 2000 value.

"[~~RSMeans~~ R.S. Means] historical cost index factor" means the ratio of the two most recent [~~RSMeans~~ R.S. Means] Historical Cost Indexes published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of this [~~RSMeans~~ R.S. Means] publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY2001). The resulting cost value that would be used in SFY2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, RSMeans does not publish index forecasts, so the most recent available indexes shall be used.

"[~~RSMeans~~ R.S. Means] [~~location factors~~ Location Factors]" means those published in the most recent available edition of Square Foot Costs. The 2000 location factors are shown in the following Table 1. They will be updated annually and distributed to providers based upon the most recent available data.

TABLE 1
[~~RSMEANS~~ R.S. MEANS] COMMERCIAL CONSTRUCTION COST
LOCATION FACTORS (2000)

Zip Code	**Principal City**	**Location Factor**
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on US Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve (Federal Reserve Statistical Release H.15 Selected Interest Rates [(~~www.bog.frb.fed.us/releases/~~)) (www.Federalreserve.gov/releases/)]. Rental rates may not fall below 9% or exceed 11% and will be updated annually on or about July 1st each year. The rate will be published and

distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1st.

"Required occupancy percentage" means an occupancy percentage of 90%.

"SFY" means State Fiscal Year (July 1st through June 30th.)

A. Fair Rental Value Payment for Capital. Effective for dates of service on or after July 1, 2001, the [~~state agency~~ DMAS] shall pay nursing facility capital related costs under a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost, including home office capital costs. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator. The Department shall review the operation and performance of the FRV methodology every two years.

B. FRV Rate Year. The FRV payment rate shall be a per diem rate determined each year for each facility, using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per

diem rate each year effective at the start of the provider's fiscal year. Data elements that are provider specific shall be revised at that time and shall rely on the [~~filed~~ settled] cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by RSMeans and the rental rate, shall be determined annually on or about July 1st, and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st.

12 VAC 30-90-37. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or 90 percent of the potential patient days for all licensed beds throughout the cost reporting period. [For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.]

B. Calculation of FRV Rental Amount**.** The facility FRV rental amount shall be equal to the facility prospective year total value times the rental rate.

1. The facility prospective year total value shall be equal to the facility prospective year replacement value minus FRV depreciation. FRV depreciation equals the prospective year replacement value multiplied by the product of facility average age and the depreciation rate. FRV depreciation cannot exceed 60% of the prospective year replacement value.

2. The facility prospective year replacement value shall be equal to the fixed capital replacement value plus the movable equipment replacement value.

C. Change of Ownership. As provided in connection with Schedule of Assets reporting, the sale of nursing facility assets after June 30, 2000 shall not result in a change to the Schedule of Assets or to the calculation of average age for purposes of reimbursement under the FRV methodology. Therefore any sale or transfer of assets after this date shall not affect the FRV per diem rate. [~~Changes of ownership for purposes of determining the FRV payment shall occur if there is a sale of stock, assets, or sales between related or unrelated parties. For purposes of this section, change of ownership shall be deemed to have occurred if there is a sale of stock, assets, or sales between related or unrelated parties.~~]

12 VAC 30-90-38. Schedule of Assets Reporting.

A. For the calculation of facility average age the Department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of

facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. This schedule shall be submitted annually by the provider on forms to be provided by the Department, and shall be audited by the Department. The principles of reimbursement for plant cost described in Article 2 shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero.

D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing $50,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a twelve-month period. For facilities with 30 or fewer beds, an amount of $25,000, rather than $50,000, shall apply. The limits of $50,000 and $25,000 shall apply only to expenditures after July 1, 2000.

E. Items reportable on the schedule of assets may be removed only when disposed of.

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the Schedule of Assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the Schedule of Assets.

G. In addition to verifying the Schedule of Assets, audits of NF allowable capital costs shall continue to be performed in accordance with regulations described in Article 2.

12 VAC 30-90-39. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider and must notify DMAS of the sale within 30 days of the date legal title passes to the purchaser. The notification [~~should~~ shall] include:

1. That a sale or transfer is about to be made or has already occurred;

2. The location and general description of the property;

3. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years;

B. The seller must file a final cost report within 150 days of the date of the facility sale.

Article ~~2~~ 4

Operating Cost Component

12VAC30-90-40. Operating cost.

A. ~~Operating~~ Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See [~~Part VII~~ Subpart VII (12 VAC 30-90-170)] for rate determination procedures for NATCEPs costs~~. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period~~. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs in Appendix I (12 VAC 30-90-272[])]. For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or 90 percent of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. [For facilities that also provide specialized care services, see 12

VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.]

~~B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.~~

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in ~~12VAC30-90-270~~. 12 VAC 30-90-271.

b. ~~Indirect~~ Effective July 1, 2001, indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA ~~and~~ , for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with

more than 60 licensed beds. ~~Indirect patient care operating costs shall include all other operating costs, not defined in 12VAC30-90-270 as direct patient care operating costs and NATCEPs costs.~~

~~c. Effective July 1, 1995, existing indirect peer group ceilings of nursing facilities shall be adjusted according to the schedule below. These adjustments shall be added to the ceiling in effect for each facility on July 1, 1995, and shall apply from that day until the end of the facility's fiscal year in progress at that time. Peer group ceilings for the subsequent fiscal year shall be calculated by adding the adjustments below to the existing interim ceiling. The resulting adjusted interim ceiling shall be increased by 100% of historical inflation to the beginning of the facility's next fiscal year to obtain the new "interim" ceiling, and by 50% of the forecast inflation to the end of the facility's next fiscal year. This action increases the number of indirect patient care operating cost peer groups to a total of eight, four peer groups for the area within the Washington DC-MD-VA MSA, and four for the rest of the state.~~

~~Licensed Bed Size~~	~~Ceiling Adjustment~~
~~1 to 30~~	~~add $1.89~~
~~31 to 60~~	~~add $1.28~~
~~61 to 90~~	~~add $0.62~~
~~Over 90~~	~~add $0.00~~

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care

Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now ~~DMAS-95~~ DMAS-80) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See 12VAC30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall ~~be used to calculate the initial direct patient care operating cost peer group medians. It shall also~~ be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. ~~The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians~~. Repealed.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An ~~SSI~~ SII rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The

SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See 12VAC30-90-300 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

~~5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.~~

~~a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987.~~

~~b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS prospective payment system.~~

~~c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.~~

~~d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.~~

5. Effective for services on and after July 1, 2001, the following [~~change~~ changes]shall be made to the direct and indirect payment methods.

a. The direct patient care[—] operating ceiling shall be set at 112% of the median of facility specific direct cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998. The median used to set the direct ceiling shall be revised every two years using more recent data. In addition, for ceilings effective during July 1, 2000, through June 30, 2002, the ceiling calculated as described herein shall be increased by two per diem amounts. The first per diem amount shall equal $21,716,649, increased for inflation from SFY2000 to SFY 2001, divided by Medicaid days in SFY 2000. The second per diem amount shall equal $1,400,000 divided by Medicaid days in SFY2000. When this ceiling calculation is completed for services after June 30, 2002, the per diem amount related to the amount of $21,716,649 shall not be added.

b. Facility specific direct cost per day amounts used to calculate direct reimbursement rates for dates of service on and after July 1, 2000, shall be increased by the two per diem amounts described in subitem a above. However, the per diem related to the amount of $21,716,649 shall be included only in proportion to the number of calendar days in the provider fiscal year the data are taken from that do not fall after July 1, 1999. That is, for a cost report from a provider fiscal year ending December 31, 1999, the specified increase would apply to about half of the year.

c. The indirect patient care operating ceiling shall be set at 106.9% of the median of facility specific indirect cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. ~~The initial peer group ceilings established under subsection A of this section shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the initial "interim" ceilings by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both subdivisions A 5 a and A 5 c of this section. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year~~. The initial peer group ceilings established under [~~12 VAC 30-90-~~

~~41~~ under this section] shall be the final peer group ceilings for a NF's first or partial cost reporting fiscal year under PIRS. Peer group ceilings for subsequent fiscal years shall be calculated by use of the adjusted medians determined at June 30, 2000, for direct and indirect cost. These adjusted medians shall be considered the 'final' interim ceilings for subsequent fiscal years. The 'final' interim ceilings determined above shall be adjusted by adding 100% of historical inflation from June 30, 2000, to the beginning of the NF's next fiscal year to obtain the new 'interim' ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year.

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Non-operating costs. ~~Allowable plant~~ Plant or capital, as appropriate, costs shall be reimbursed in accordance with ~~this article~~ Articles 1, 2, and 3. Plant costs shall not include the component of cost related to making or producing a supply or service. NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant /capital[~~,~~] cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of non-reimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of non-reimbursable plant or capital, as

appropriate, costs and NATCEPs costs shall be reflected in the year in which the non-reimbursable costs are included.

F. ~~For~~ Effective July 1, 2001, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings ~~under the PIRS.~~

1. The following table presents four incentive examples ~~under the PIRS~~:

Peer Group Ceilings	**Allowable Cost Per Day**	**~~% of~~ Difference**	**~~Sliding~~ % of Ceiling**	**Sliding Scale**	**Scale % Difference**
$ 30.00	$ 27.00	$ 3.00	10 %	$ .30	10 %
30.00	22.50	7.50	25 %	1.88	25 %
30.00	20.00	10.00	33 %	2.50	25 %
30.00	30.00	0	0		

2. ~~Separate efficiency~~ Efficiency incentives shall be calculated only for ~~both~~ the ~~direct and~~ indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12VAC30-90-42. ~~Phase-in period~~. Repealed.

~~A. To assist NFs in converting to the PIRS methodology, a phase-in period shall be provided until June 30, 1992.~~

~~B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by 12VAC30-90-41 and 67% of the "current" operating rate determined by subsection D below.~~

~~C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by 12VAC30-90-41 and 33% of the "current" operating rate determined by subsection D below.~~

~~D. The following methodology shall be applied to calculate a NF's "current" operating rate:~~

~~1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.~~

~~2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in 12VAC30-90-41 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See 12VAC30-90-300 for example calculations.~~

12VAC30-90-43. ~~Nursing facility rate change~~. Repealed.

~~For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.~~

12VAC30-90-44 to 12VAC30-90-49. [Reserved]

Article ~~3~~ 5

Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

C. Operating costs.

1. Direct patient care operating costs shall be defined in [~~12VAC30-90-270~~. 12VAC30-90-271].

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and non-legend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with 12VAC30-80-10 et seq.

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in 12VAC30-90-270 [et seq.], which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

D. Allowances/goodwill. Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as [~~an~~] allowable [~~cost~~ costs].

~~E. Cost of protecting employees from blood borne pathogens. Effective July 1, 1994, reimbursement of allowable costs shall be adjusted in the following way to recognize the costs of~~

~~complying with requirements of the Occupational Safety and Health Administration (OSHA) for protecting employees against exposure to blood borne pathogens.~~

~~1. Hepatitis B immunization. The statewide median of the reasonable acquisition cost per unit of immunization times the number of immunizations provided to eligible employees during facility fiscal years ending during SFY 1994, divided by Medicaid days in the same fiscal period, shall be added to the indirect peer group ceiling effective July 1, 1994. This increase to the ceilings shall not exceed $.09 per day for SFY 1995.~~

~~2. Other OSHA compliance costs. The indirect peer group ceilings shall be increased by $.07, effective July 1, 1994, to recognize continuing OSHA compliance costs other than immunization.~~

~~3. Data submission by nursing facilities. Nursing facilities shall provide for fiscal years ending during SFY 1994, on forms provided by DMAS, (i) the names, job titles and social security numbers of individuals immunized, the number of immunizations provided to each and the dates of immunization; and (ii) the acquisition cost of immunization.~~

12VAC30-90-51. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of [~~12VAC30-90-34 B 2~~ 12 VAC 30-90-34-B1].

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See 12VAC30-90-290.)

B. "Related to the provider" shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by

a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

~~E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in 12VAC30-90-31. Reimbursement shall be in accordance with subsection A of this section with the limitations stated in 12VAC30-90-31 B.~~

[E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in 12VAC30-90-31. Reimbursement shall be in accordance with subsection A of this section with the limitations stated in 12VAC30-90-31 B.]

12VAC30-90-52. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or nonowners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule

covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the nursing facility administrator (see 12VAC30-90-290, Cost reimbursement limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employee/owner or his beneficiary), director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and non-owner) shall be based upon a 40-hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a nursing facility as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40-hour week as an administrator. The additional duties must be necessary for the operation of the nursing facility and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transactions or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

12VAC30-90-53. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

12VAC30-90-54. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of 12VAC30-90-280.

12VAC30-90-55. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. For cost reports filed on or after August 1, 1992, an interim settlement shall be made by DMAS within 180 days after receipt and review of the cost report. [~~The 180-day time frame shall similarly apply to cost reports filed but not interim settled as of August 1, 1992~~.] The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists:

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/non-acceptable cost report.

12VAC30-90-56. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in 12VAC30-90-290.

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

12VAC30-90-57. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

12VAC30-90-58. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is

not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

12VAC30-90-59. [Reserved]

Article 4~~-~~ 6

New Nursing Facilities

12VAC30-90-60. Interim rate.

A. A new facility shall be defined as follows:

1. A facility that is newly enrolled and new construction has taken place through the COPN process; or

2. A facility that is newly enrolled which was previously denied payments for new admissions and was subsequently terminated from the program.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. A replacement facility or one that has changed location may not be considered a new facility if it serves the same inpatient population. An exception may be granted by DMAS if the provider can demonstrate that the occupancy substantially changed as a result of the facility being replaced or changing location. A [~~change~~ decline] in [the replacement facility's] total occupancy of 20 [~~percent~~ percentage points, in the replacement facility's first cost reporting period,] shall be considered to indicate a substantial change when compared to [the lower of] the [old facility's] previous two prior cost reporting periods. [The replacement facility shall receive the previous operator's operating rates if it does not qualify to be considered a new facility.]

D. A change in either ownership or adverse financial conditions (e.g. bankruptcy), or both, of a provider does not change a nursing facility's status to be considered a new facility.

~~A.~~E. ~~For~~ Effective July 1, 2001, for all new ~~or expanded~~ NFs the ~~95%~~ 90% occupancy requirement for indirect and capital costs shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed ~~12~~ 13 months from the date of the NF's certification.

~~B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.~~

~~C~~. F. The ~~95%~~ 90% occupancy requirement for indirect and capital costs shall be applied to the first and subsequent cost reporting periods' actual indirect and capital costs for establishing

such NF's second and future cost reporting periods' prospective reimbursement rates. The ~~95%~~ 90% occupancy requirement shall be considered as having been satisfied if the new NF achieved a ~~95%~~ 90% occupancy at any point in time during the first cost reporting period.

~~D.~~ G. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

~~E.~~H. ~~On~~ Effective July 1, 2001, on the first day of its second cost reporting period, a new nursing facility's interim plant or capital, as appropriate, rate shall be converted to a per diem amount by dividing ~~it~~ its allowable plant/capital costs for its first cost reporting period by 90 percent of the potential number of patient days for all ~~computed as 95% of the daily~~ licensed ~~bed~~ beds ~~complement~~ during the first cost reporting period.

~~F. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under 12VAC30-90-42.~~

~~G.~~ I. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

12 VAC 30-90-61 through 12 VAC 30-90-64. Reserved.

12VAC30-90-65. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in 12VAC30-90-60 ~~A, C,~~ E, ~~and~~ F , and H.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If indirect costs are below ~~those ceilings~~ the ceiling, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable indirect operating cost and the peer group ceiling used to set the interim rate. (Refer to 12VAC30-90-41 F.)

12 VAC 30-90-66 through 12 VAC 30-90-69. Reserved.

Article ~~5~~ 7

Cost Reports

12VAC30-90-70. Cost report submission.

A. Cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following (note that if the audited financial

statements required by subdivisions 3 a and 6 b of this subsection are received not later than 120 days after the provider's fiscal year end and all other items listed are received not later than 90 days after the provider's fiscal year end, the cost report shall be considered to have been filed at 90 days):

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by subdivision [~~6~~ 7] of this subsection;

b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

c. Schedule of investments by type (stock, bond, etc.), amount, and current market value;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule;

6. Schedule of Assets as defined in 12 VAC 30-90-37.

7. Nursing facilities which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require,

disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

c. The nursing facility's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

~~7.~~ 8. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

12 VAC 30-90-71 through 12 VAC 30-90-74. Reserved.

12VAC30-90-75. Reporting form; accounting method; cost report extensions; fiscal year changes.

A. All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

B. The accrual method of accounting and cost reporting is mandated for all providers.

C. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

D. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

12 VAC 30-90-76 through 12 VAC 30-90-79. Reserved.

Article ~~6~~ 8

Prospective Rates

12VAC30-90-80. Time frames.

A. For cost reports filed on or after August 1, 1992, a prospective rate shall be determined by DMAS within ~~90~~ 180 days of the receipt of a complete cost report. (See 12VAC30-90-70 A.) ~~The 180-day time frame shall similarly apply to cost reports filed but for which a prospective rate has not been set as of August 1, 1992.~~ Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional ~~90~~ 120 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

12 VAC 30-90-81 through 12 VAC 30-90-89. Reserved.

Article ~~7~~ 9

Retrospective Rates

12VAC30-90-90. Retrospective rates.

The retrospective method of reimbursement shall be used for mental health/mental retardation facilities.

12VAC30-90-91 to 90-109. [Reserved]

Article ~~8~~ 10

Record Retention

12VAC30-90-110. Record retention.

A. Time frames. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

Certain information must be maintained for the duration of the provider's participation in the [~~DMAS~~ Medicaid program] and until such time as all cost reports are settled. Examples of such information are set forth in subsection B of this section.

B. Types of records to be maintained. Information which must be maintained for the duration of the provider's participation in the [~~DMAS~~ Medicaid program] includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules; and

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

C. Record availability. The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

12 VAC 30-90-111 through 12 VAC 30-90-119. Reserved.

Article ~~9~~ 11

Audits

12VAC30-90-120. Audit overview; scope of audit.

A. Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

B. The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, schedule of assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and

questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

12VAC30-90-121. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

12VAC30-90-122. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

12VAC30-90-123. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report or reports regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), if revised, which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

12VAC30-90-124. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in 12VAC30-90-70 B.

12VAC30-90-125. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of 12VAC30-90-123.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in 12VAC30-90-123 and 12VAC30-90-124, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

12VAC30-90-126 to 12VAC30-90-129. [Reserved]

Subpart III

Appeals

12VAC30-90-130. Dispute resolution for nonstate operated nursing facilities. Repealed.

~~A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14:1 et seq. and § 32.1-325.1 of the Code of Virginia.~~

~~B. Nonappealable issues are identified below:~~

~~1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.~~

~~2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.~~

~~3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.~~

~~4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.~~

~~5. The establishment of separate ceilings for direct operating costs and indirect operating costs.~~

~~6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.~~

~~7. The development of Service Intensity Indexes based on:~~

~~a. Determination of resource indexes for each patient class that measures relative resource cost.~~

~~b. Determination of each NF's average relative resource cost index across all patients.~~

~~c. Standardizing the average relative resource cost indexes of each NF across all NF's.~~

~~8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS 95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.~~

~~9. The establishment of payment rates based on service intensity indexes.~~

12VAC30-90-131. Conditions for appeal. Repealed.

~~An appeal shall not be heard until the following conditions are met:~~

~~1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.~~

~~2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by DMAS.~~

~~3. All first level appeal requests shall be filed in writing with the DMAS within 90 business days following the date of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.~~

12VAC30-90-132. Appeal procedure. Repealed.

~~A. There shall be two levels of administrative appeal.~~

~~B. Informal appeals shall be decided by the Director of the Appeals Division after an informal fact finding conference is held. The decision of the Director of the Appeals Division shall be sent in writing to the provider within 90 business days following conclusion of the informal fact finding conference.~~

~~C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 business days of the date of the initial decision.~~

~~D. Within 30 business days of the date of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.~~

~~E. The director shall notify the provider of his final decision within the time frames set for disposition of appeals in this subpart and the Administrative Process Act, § 9-6.14:1 et seq. of the Code of Virginia.~~

~~F. The director's final written decision shall conclude the provider's administrative appeal.~~

~~G. Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.~~

12VAC30-90-133. Appeals time frames. Repealed.

~~Appeal time frames noted throughout this section may be extended for the following reasons:~~

~~1. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.~~

~~2. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.~~

~~3. Extensions of time frames shall be granted to the DMAS for good cause shown.~~

~~4. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.~~

~~5. Disputes relating to the time lines established in 12VAC30-90-132 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.~~

12VAC30-90-134. Dispute resolution for state-operated NFs.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

2. The appropriate DMAS division must receive the reconsideration request within 30 business days after the date of a DMAS Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

E. DMAS director review. A state-operated provider may, within 30 business days after the date of the informal review decision of the division director, request that the DMAS Director or his designee review the decision of the division director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 business days after the date of the decision of the DMAS Director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other cabinet secretary as appropriate. Any determination by such secretary or secretaries shall be final.

12VAC30-90-135. Reimbursement of legal fees associated with appeals having substantial merit. Repealed.

~~A. The Department of Medical Assistance Services shall reimburse a nursing facility for reasonable and necessary legal fees associated with an informal or formal appeal brought pursuant to the Administrative Process Act, only if the nursing facility substantially prevails on the merit of the appeal. The term "substantially prevails" is defined as being successful on more than 50% of the issue as appealed and on more than 50% of the amount under appeal. The reimbursement of legal fees remains subject to the State Plan for Medical Assistance and all existing ceilings. Any legal fees claimed must be supported by adequate, detailed, and verifiable documentation.~~

~~B. Subject to the requirements of subsection A of this section, the reimbursable legal fees will be included in the calculation of total allowable costs in the fiscal year the appeal process is concluded and Medicaid will reimburse the nursing facility for its Medicaid proportionate share.~~

12VAC30-90-136. Elements of the capital payment methodology that shall not be subject to appeal shall be:

1. The definitions provided in Article 3, and the application of those definitions to the FRV rate calculation.

2. The transition policy described in Article 1.

3. The formula for determining the FRV per diem rate described in Article 3.

4. The calculation of the FRV rental amount described in Article 3.

5. The exclusion of certain beds from the transition policy, as provided in Article 3.

12VAC30-90-137 to 12VAC30-90-139. [Reserved]

Subpart IV

Individual Expense Limitation

12VAC30-90-140. Individual expense limitation.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in 12VAC30-90-290, Cost Reimbursement Limitations.

[12 VAC 30-90-141 to 12 VAC 30-90-149. Reserved.]

Subpart V

Cost Report Preparation Instructions

12VAC30-90-150. Cost report preparation instructions.

Instructions for preparing NF cost reports will be provided by the DMAS.

[12 VAC 30-90-151 to 12 VAC 30-90-159. Reserved.]

Subpart VI

Stock Transactions

Article 1.

Plant Cost Applicable.

12VAC30-90-160. Stock acquisition; merger of unrelated and related parties.

A. [~~The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets~~. The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets.] Any cost associated with ~~such~~ an acquisition of capital stock shall not be an allowable cost. [~~The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.~~ The provider

selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.]

B. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

The non-surviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

C. The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

12 VAC 30-90-161 through 90-164. Reserved.

Article 2.

Capital Cost Applicable.

12 VAC 30-90-165. Stock acquisition; merger of unrelated and related parties.

A. The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with ~~such~~ an acquisition of capital stock shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

B. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

The non-surviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

C. The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

12 VAC 30-90-166 through 90-169. Reserved.

Subpart VII

Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Programs (NATCEPs)

12VAC30-90-170. NATCEPs costs.

A. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

B. NATCEPs costs shall be as defined in 12VAC30-90-270.

C. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

D. The NATCEPs interim reimbursement rate determined in subsection C of this section shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

E. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in subsection C of this section times the Medicaid patient days from the DMAS MMR-240.

F. Disallowance of non-reimbursable NATCEPs costs shall be reflected in the year in which the non-reimbursable costs were claimed.

G. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in 12VAC30-90-55 A.

[12 VAC 30-90-171 to 12 VAC 30-90-179. Reserved.]

Subpart VIII

Criminal Records Checks for Nursing Facility Employees

12VAC30-90-180. Criminal records checks.

A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

B. A licensed nursing facility shall not hire for compensated employment persons who have been convicted of:

1. Murder;

2. Abduction for immoral purposes as set out in § 18.2-48 of the Code of Virginia;

3. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia;

4. Arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2 of the Code of Virginia;

5. Pandering as set out in § 18.2-355 of the Code of Virginia;

6. Crimes against nature involving children as set out in § 18.2-361 of the Code of Virginia;

7. Taking indecent liberties with children as set out in §§ 18.2-370 or 18.2-370.1 of the Code of Virginia;

8. Abuse and neglect of children as set out in § 18.2-371.1 of the Code of Virginia;

9. Failure to secure medical attention for an injured child as set out in § 18.2-314 of the Code of Virginia;

10. Obscenity offenses as set out in §18.2-374.1 of the Code of Virginia; or

11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369 of the Code of Virginia.

C. The provider shall obtain a sworn statement or affirmation from every applicant disclosing any criminal convictions or pending criminal charges for any of the offenses specified in subsection B of this section regardless of whether the conviction or charges occurred in the Commonwealth.

D. The provider shall obtain an original criminal record clearance or an original criminal record history from the Central Criminal Records Exchange for every person hired. This information shall be obtained within 30 days from the date of employment and maintained in the employees' files during the term of employment and for a minimum of five years after employment terminates for whatever reason.

E. The provider may hire an applicant whose misdemeanor conviction is more than five years old and whose conviction did not involve abuse or neglect or moral turpitude.

F. Reimbursement to the provider will be handled through the cost reporting form provided by the DMAS and will be limited to the actual charges made by the Central Criminal Records Exchange for the records requested. Such actual charges will be a pass-through cost which is not a part of the operating or plant cost components.

Subpart IX

Use of MMR-240

12VAC30-90-190. Use of MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

Subpart X

Commingled Investment Income

12VAC30-90-200. Commingled investment income.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

Subpart XI

Provider Notification

12VAC30-90-210. Provider notification.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

Subpart XII

Start-up Costs and Organizational Costs

12VAC30-90-220. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

12VAC30-90-221. Time frames.

~~A. Start-up cost time frames.~~

~~1~~. A. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or non-allowable functions, to the time the areas are used for their intended purposes.

~~2.~~ B. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

~~3.~~ C. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

~~4~~. D. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

[~~B~~. E.] Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a non-revenue-producing patient care area or non-allowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

12VAC30-90-222. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs

extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

12VAC30-90-223 to 12VAC30-90-229. [Reserved]

Subpart XIII

DMAS Authorization

12VAC30-90-230. Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and non-patient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in 12VAC30-90-51 who provide assets and other goods and services to the provider.

Subpart XIV

Home Office Costs

12VAC30-90-240. Home office operating costs.

A. Home office operating costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

B. Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

C. Home office operating costs shall be allocated in accordance with § 2150.3, PRM-15.

D. Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

E. Allowable and non-allowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

F. Item 398 D Chapter 723 of 1987 Acts of Assembly (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

Subpart XV

Refund of Overpayments

12VAC30-90-250. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. ~~Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.~~

12VAC30-90-251. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

12VAC30-90-252. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

12VAC30-90-253. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. The provider must make payments in accordance with the proposed schedule while the schedule is pending approval. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

12VAC30-90-254. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

12VAC30-90-255 to 12VAC30-90-259. [Reserved]

Subpart XVI

Revaluation of Assets

12VAC30-90-260. ~~Change of ownership~~. Repealed.

~~A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:~~

~~1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the~~

~~aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or~~

~~2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.~~

~~B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:~~

~~1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or~~

~~2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).~~

~~C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See 12VAC30-90-34 B 3 for the definition of "bona fide" sale).~~

~~D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:~~

~~1. The amounts computed in subsection B above;~~

~~2. Appraised replacement cost value; or~~

~~3. Purchase price.~~

~~E. Date of acquisition is deemed to have occurred on the date legal title passed to the seller. If a legal titling date is not determinable, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.~~

12 VAC 30-90-261 through 12 VAC 30-90-263. Reserved.

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with 12VAC30-60-40 E and H, 12VAC30-60-320 and 12VAC30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the categories of Ventilator Dependent Care, Comprehensive Rehabilitation Care, and Complex Health Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12VAC30-90-271 and 12VAC30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article ~~3~~ 5 (12VAC30-90-50 et seq.) of Part II of this chapter and of Appendix III (12VAC30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 12VAC30-90-41.

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

a. Statewide ceiling. The statewide routine operating ceiling shall be the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1, 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the 12 facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percentage of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most

recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal year.

b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated.

c. The percentage of the statewide routine operating ceiling relating to the nursing labor and non-labor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the nursing facility's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each nursing facility will be based on all specialized care patient days rendered during the six-month period prior to that in which the ceiling applies (see subdivision 6 below).

5. Normalized case mix index (NCMI). Case mix shall be measured by RUG-III nursing-only index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights

developed at the national level by the Health Care Financing Administration (HCFA) (see 12VAC30-90-320) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

a. The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six-month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

b. The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care Nursing facilities in the state during the six months prior to the six-month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six-month period for which a provider-specific rate must be set.

c. The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from (a) above divided by the statewide CMI from (b) above.

d. Each facility's NCMI shall be updated semiannually, at the start and the midpoint of the facility's fiscal year.

e. Patient days for which the lowest RUG-III weight is imputed, as provided in subdivision 14 c of this section, shall not be included in the calculation of the NCMI.

6. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

a. An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and non-labor operating base cost per day for each semiannual period of the facility's fiscal year.

b. The NCMI calculated for the second semiannual period of the previous fiscal year shall be divided by the average of that (previous) fiscal year's two semiannual NCMIs to yield an "NCMI cost rate adjustment" to the prospective nursing labor and nonlabor operating cost base rate in the first semiannual period of the subsequent fiscal year.

c. The NCMI determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semiannual NCMIs to determine the NCMI cost rate adjustment to the prospective nursing labor and

nonlabor operating base cost per day in the second semiannual period of the subsequent fiscal year.

See 12VAC30-90-310 for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semiannual NCMI adjustments to the prospective routine operating base cost rates.

7. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere.

8. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. See 12VAC30-90-290 for the cost reimbursement limitations.

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 12VAC30-90-290 for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet specialized care Complex Health Care Category wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

9. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

10. Capital costs ~~(excluding pediatric specialized care units~~). Effective July 1, 2000, ~~Capital~~ capital cost reimbursement shall be in accordance with 12 VAC 30-90-35 through 12 VAC 30-90-37 inclusive of the ~~current~~ NHPS, except that the ~~95%~~ 90% ~~(85% if applicable~~) occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement the ~~95%~~ 90% ~~(85% if applicable~~) occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care. ~~An occupancy requirement of 70% shall be applied to distinct part pediatric specialized care units.~~

[To apply this requirement the following calculation shall be carried out.

a. Licensed beds including specialized care beds, times days in the cost reporting period shall equal available days.
b. 90% of available days shall equal 90% occupancy days.
c. 90% occupancy days, minus actual resident days including specialized care days shall equal the shortfall of days if it is positive. It shall be set to zero if it is negative.
d. Actual resident days not including specialized care days, plus the shortfall of days shall equal the minimum number of days to be used to calculate the capital cost per day.]

11. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS.

12. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be computed as follows:

a. The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (i) the weighted average capital cost per day developed from the 1994 audit data and (ii) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in subdivision 4 a of this subsection.

b. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 and 5 of this section.

c. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

13. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than ~~95% or 85%~~

90%. ~~An interim capital rate will be calculated from the latest cost report and retrospectively cost settled on the respective specialized care provider's cost reporting period.~~

14. MDS data submission. MDS data relating to specialized care patients must be submitted to the department in a submission separate from that which applies to all nursing facility patients.

a. Within 30 days of the end of each month, each specialized care nursing facility shall submit to the department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid specialized care patient in the nursing facility. This shall include (i) the MDS required within 14 days of admission to the nursing facility (if the patient is admitted as a specialized care patient), (ii) the one required by the department upon admission to specialized care, (iii) the one required within 12 months of the most recent full assessment, and (iv) the one required whenever there is a significant change of status.

b. In addition to the monthly data submission required in (a) above, the same categories of MDS data required in (a) above shall be submitted for all patients receiving specialized care from January 1, 1996, through December 31, 1996, and shall be due February 28, 1997.

c. If a provider does not submit a complete MDS record for any patient within the required timeframe, the department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. Case mix measures in the initial semiannual periods. In any semiannual periods for which calculations in 12VAC39-90-310 requires an NCMI from a semiannual period beginning before January 1996, the case mix used shall be the case mix applicable to the first semiannual period beginning after January 1, 1996, that is a semiannual period in the respective provider's fiscal period. For example, December year-end providers' rates applicable to the month of December 1996, would normally require (in Appendix I (12VAC30-90-270 et seq.) of Part III of this chapter) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMIs that shall be used will be those applicable to the next semiannual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have it's rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997.

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of 12VAC30-90-70 and 12VAC30-90-80 shall apply.

12 VAC 30-90-265. Reserved.

12VAC30-90-266. Traumatic Brain Injury (TBI) payment.

DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System. Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. ~~The value of the rate add-on shall be $22 on August 19, 1998, and thereafter.~~ The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, not to exceed $50 per patient day, and any changes will be published and distributed to the providers. (Refer to 12VAC30-90-330, Traumatic brain injury diagnoses, for related resident and provider requirements.)

12 VAC 30-90-267 through 12 VAC 30-90-269. Reserved.

CERTIFIED:

_____ _____

Date

C. Mack Brankley, Acting Director

Dept. of Medical Assistance Services

Part III

Nursing Home Payment System Appendices

12VAC30-90-270. Uniform Expense Classification. (Appendix I.)

This appendix describes the classification of expenses applicable to the Nursing Facility Payment System.

Allowable expenses shall meet all of the following requirements: necessity, reasonableness, non-duplication, related to patient care, not exceeding the limits and/or ceilings established in the Payment System and meet applicable Medicare principles of reimbursement. All of the references to 12 VAC 30-90-270 occurring in previous Part II shall be understood to include 12 VAC 30-90-270 through 12 VAC 30-90-276.

12VAC30-90-271. Direct patient care operating.

A. Nursing service expenses.

1. Salary--nursing administration. Gross salary (includes sick pay, holiday pay, vacation pay, staff development pay and overtime pay) of all licensed nurses in supervisory positions defined as follows (Director of Nursing, Assistant Director of Nursing, nursing unit supervisors and patient care coordinators).

2. Salaries--RNs. Gross salary of registered nurses.

3. Salaries--LPNs. Gross salary of licensed practical nurses.

4. Salaries--Nurse Aides. Gross salary of certified nurse aides.

5. Nursing employee benefits. Benefits related to registered nurses, licensed practical nurses, certified nurse aides and nursing administration personnel as defined in subdivision 1 of this subsection. See 12VAC30-90-272 B for description of employee benefits.

6. Contract nursing services. Cost of registered nurses, licensed practical nurses, and certified nurse aides on a contract basis.

7. Supplies. Cost of supplies, including nursing and charting forms, medication and treatment records, physician order forms.

8. Professional fees. Medical director and pharmacy consultant fees.

B. Minor medical and surgical supplies.

1. Salaries--medical supply. Gross salary of personnel responsible for procurement, inventory and distribution of minor medical and surgical supplies.

2. Medical supply employee benefits. Benefits related to medical supply personnel. See 12VAC30-90-272 B for description of employee benefits.

3. Supplies. Cost of items for which a separate identifiable charge is not customarily made, including, but not limited to, colostomy bags; dressings; chux; rubbing alcohol; syringes; patient gowns; basins; bed pans; ice-bags and canes, crutches, walkers, wheel chairs, traction equipment and other durable medical equipment for multi-patient use.

4. Oxygen. Cost of oxygen for which a separate charge is not customarily made.

5. Nutrient/tube feedings. Cost of nutrients for tube feedings.

6. Incontinence services. Cost of disposable and non-disposable incontinence supplies. The laundry supplies or purchased commercial laundry service for non-disposable incontinent services.

C. Ancillary Service Cost. Allowable ancillary service costs represents gross salary and related employee benefits of those employees engaged in covered ancillary services to Medicaid recipients, cost of all supplies used by the respective ancillary service departments, cost of

ancillary services performed on a contract basis by other than employees and all other costs allocated to the ancillary service cost centers in accordance with Medicare principles of reimbursement.

Following is a listing all covered ancillary services:

1. Radiology

2. Laboratory

3. Inhalation therapy

4. Physical therapy

5. Occupational therapy

6. Speech therapy

7. EKG

8. EEG

9. Medical supplies charged to patient.

12VAC30-90-272. Indirect patient care operating costs.

A. Administrative and general.

1. Administrator/owner assistant administrator. Compensation of individuals responsible for administering the operations of the nursing facility. (See 12VAC30-90-50 and Appendix III (12VAC30-90-290) for limitations.)

2. Other administrative and fiscal services. Gross salaries of all personnel in administrative, personnel, fiscal, billing and admitting, communications and purchasing departments.

3. Management fees. Cost of fees for providing necessary management services related to nursing facility operations. (See Appendix III (12VAC30-90-290) for limitations.)

4. Professional fees--accounting. Fees paid to independent outside auditors and accountants.

5. Professional fees--legal. Fees paid to attorneys. (See Appendix III (12VAC30-90-290) for limitations.)

6. Professional fees--other. Fees, other than accounting or legal, for professional services related to nursing facility patient care.

7. Director's fees. Fees paid for attendance at scheduled meetings which serve as reimbursement for time, travel, and services provided. (See Appendix III (12VAC30-90-290) for limitations.)

8. Membership fees. Fees related to membership in health care organizations which promote objectives in the providers' field of health care activities. (See Appendix III (12VAC30-90-290) for limitations.)

9. Advertising (classified). Cost of advertising to recruit new employees and yellow pages advertising.

10. Public relations. Cost of promotional expenses including brochures and other informational documents regarding the nursing facility.

11. Telephone. Cost of telephone service used by employees of the nursing facility.

12. Subscriptions. Cost of subscribing to newspapers, magazines, and periodicals.

13. Office supplies. Cost of supplies used in administrative departments (e.g., pencils, papers, erasers, staples).

14. Minor furniture and equipment. Cost of furniture and equipment which does not qualify as a capital asset.

15. Printing and postage. Cost of reproducing documents which are reasonable, necessary and related to nursing facility patient care and cost of postage and freight charges.

16. Travel. Cost of travel (airfare, auto mileage, lodging, meals, etc. by administrator or other authorized personnel on official nursing facility business). (See 12VAC30-90-290 for limitations.)

17. Auto. All costs of maintaining nursing facility vehicles, including gas, oil, tires, licenses, maintenance of such vehicles.

18. License fees. Fees for licenses, including state, county, and local business licenses, and VHSCRC filing fees.

19. Liability insurance. Cost of insuring the facility against liability claims, including malpractice.

20. Interest. Other than mortgage and equipment.

21. Amortization/start-up costs. Amortization of allowable Start-Up Costs (See 12VAC30-90-220).

22. Amortization/organizational costs. Amortization of allowable organization costs (See 12VAC30-90-220).

B. Employee benefits.

1. FICA (Social Security). Cost of employer's portion of Social Security Tax.

2. State unemployment. State unemployment insurance costs.

3. Federal unemployment. Federal unemployment insurance costs.

4. Workers' compensation. Cost of workers' compensation insurance.

5. Health insurance. Cost of employer's contribution to employee health insurance.

6. Group life insurance. Cost of employer's contribution to employee group life insurance.

7. Pension plan. Employer's cost of providing pension program for employees.

8. Other employee benefits. Cost of awards and recognition ceremonies for recognition and incentive programs, disability insurance, child care, and other commonly offered employee benefits which are nondiscriminatory.

C. Dietary expenses.

1. Salaries. Gross salary of kitchen personnel, including dietary supervisor, cooks, helpers and dishwashers.

2. Supplies. Cost of items such as soap, detergent, napkins, paper cups, and straws.

3. Dishes and utensils. Cost of knives, forks, spoons, plates, cups, saucers, bowls and glasses.

4. Consultants. Fees paid to consulting dietitians.

5. Purchased services. Costs of dietary services performed on a contract basis.

6. Food. Cost of raw food.

7. Nutrient oral feedings. Cost of nutrients in oral feedings.

D. Housekeeping expenses.

1. Salaries. Gross salary of housekeeping personnel, including housekeepers, maids and janitors.

2. Supplies. Cost of cleaners, soap, detergents, brooms, and lavatory supplies.

3. Purchased services. Cost of housekeeping services performed on a contract basis.

E. Laundry expenses.

1. Salaries. Gross salary of laundry personnel.

2. Linen. Cost of sheets, blankets, and pillows.

3. Supplies. Cost of such items as soap, detergent, starch and bleach.

4. Purchased services. Cost of other services, including commercial laundry service.

F. Maintenance and operation of plant.

1. Salaries. Gross salary of personnel involved in operating and maintaining the physical plant, including maintenance men or plant engineer and security services.

2. Supplies. Cost of supplies used in maintaining the physical plant, including light bulbs, nails, lumber, glass.

3. Painting. Supplies and contract services.

4. Gardening. Supplies and contract services.

5. Heating. Cost of heating oil, natural gas, or coal.

6. Electricity. Self-explanatory.

7. Water, sewer, and trash removal. Self-explanatory.

8. Purchased services. Cost of maintaining the physical plant, fixed equipment, movable equipment and furniture and fixtures on a contract basis.

9. Repairs and maintenance. Supplies and contract services involved with repairing the facility's capital assets.

G. Medical records expenses.

1. Salaries--medical records. Gross salary of licensed medical records personnel and other department personnel.

2. Utilization review. Fees paid to physicians attending utilization review committee meetings.

3. Supplies. All supplies used in the department.

4. Purchased services. Medical records services provided on a contract basis.

H. Quality assurance services.

1. Salaries. Gross salary of personnel providing quality assessment and assurance activities.

2. Purchased services. Cost of quality assessment and assurance services provided on a contract basis.

3. Supplies. Cost of all supplies used in the department or activity.

I. Social service expenses.

1. Salaries. Salary of personnel providing medically-related social services. A facility with more than 120 beds must employ a full-time qualified social worker.

2. Purchased services. Cost of medically-related social services provided on a contract basis.

3. Supplies. Cost of all supplies used in the department.

J. Patient activity expenses.

1. Salaries. Gross salary of personnel providing recreational programs to patients, such as arts and crafts, church services and other social activities.

2. Supplies. Cost of items used in the activities program (i.e., games, art and craft supplies and puzzles).

3. Purchased services. Cost of services provided on a contract basis.

K. Educational activities expenses. (Other than NATCEPs costs, see 12VAC30-90-270.)

1. Salaries. Gross salaries of training personnel.

2. Supplies. Cost of all supplies used in this activity.

3. Purchased services. Cost of training programs provided on a contract basis.

L. Other nursing Administrative costs.

1. Salaries--other nursing administration. Gross salaries of ward clerks and nursing administration support staff.

2. Subscriptions. Cost of subscribing to newspapers, magazines and periodicals.

3. Office supplies. Cost of supplies used in nursing administrative departments (e.g., pencils, papers, erasers, staples).

4. Purchased services. Cost of nursing administrative consultants, ward clerks, nursing administration support staff performed on a contract basis.

5. Advertising (classified). Cost of advertising to recruit all nursing service personnel.

M. Home office costs. Allowable operating costs incurred by a home office which are directly assigned to the nursing facility or pooled operating costs that are allocated to the nursing facility in accordance with 12VAC30-90-240.

12VAC30-90-273. Plant costs.

A. Interest.

1. Building interest. Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the nursing facility's real property. (See 12VAC30-90-30 for Limitations.)

2. Equipment interest. Interest paid or accrued on notes, chattel mortgages and other loans, the proceeds of which were used to purchase the nursing facility's equipment. (See 12VAC30-90-30 for Limitations.)

B. Depreciation (12VAC30-90-50).

1. Building depreciation. Depreciation on the nursing facility's building.

2. Building improvement depreciation. Depreciation on major additions or improvements to the nursing facility (i.e., new laundry or dining room).

3. Land improvement depreciation. Depreciation of improvements made to the land occupied by the facility (i.e., paving, landscaping).

4. Fixed and movable equipment depreciation. Depreciation on capital assets classified as fixed and movable equipment in compliance with American Hospital Association Guidelines.

5. Leasehold improvement depreciation. Depreciation on major additions or improvements to building or plant where the facility is leased and the costs are incurred by the lessee (tenant).

6. Automobile depreciation. Depreciation of those vehicles utilized solely for facility/patient services.

C. Lease/rental.

1. Building rental. Rental amounts paid by the provider on all rented or leased real property (land and building).

2. Equipment rental. Rental amounts paid by the provider on leased or rented furniture and equipment.

D. Taxes.

1. Property taxes. Amount of taxes paid on the facility's property, plant and equipment.

E. Insurance.

1. Property insurance. Cost of fire and casualty insurance on buildings and equipment.

2. Mortgage insurance. Premiums required by the lending institution, if the lending institution is made a direct beneficiary and if premiums meet Medicare principles of reimbursement criteria for allowability.

F. Amortization--deferred financing costs. Amortization of deferred financing costs (those costs directly incident to obtaining financing of allowable capital costs related to patient care services such as legal fees; guarantee fees; service fees; feasibility studies; loan points; printing and engraving costs; rating agency fees). These deferred financing costs should be capitalized and amortized over the life of the mortgage.

G. Home office capital costs. Allowable plant costs incurred by a home office which are directly identified to the nursing facility or pooled capital costs that are allocated to the nursing facility in accordance with 12VAC30-90-240.

12VAC30-90-274. Non-allowable expenses.

Non-allowable expenses include but are not limited to the following:

A. Barber and beautician. Direct and indirect operating and capital costs related to the provision of beauty and barber services to patients.

B. Personal items. Cost of personal items, such as cigarettes, toothpaste, and shaving cream sold to patients.

C. Vending machines. Cost of items sold to employees and patients including candy bars and soft drinks.

D. Television/telephones. Cost of television sets and telephones used in patient rooms.

E. Gift shop. Direct and indirect operating and capital cost related to the provision of operating a gift shop.

F. Insurance--officers. Cost of life insurance on officers, owners and key employees where the provider is a direct or indirect beneficiary.

G. Income taxes. Taxes on net income levied or expected to be levied by any governmental entity.

H. Contributions. Amounts donated to charitable or other organizations which have no direct effect on patient care.

I. Deductions from revenue. Accounts receivable written off as bad debts, charity, courtesy, or from contractual agreements are non-allowable expenses.

J. Advertising. The cost of advertisements in magazines, newspapers, trade publications, radio, and television and certain home office expenses as defined in PRM-15.

K. Cafeteria. Cost of meals to other than patients.

L. Pharmacy. Cost of all prescribed legend and nonlegend drugs.

M. Medical supplies. Cost of medical supplies to other than patients.

N. Plant costs. All plant costs not available for nursing facility patient care-related activities are nonreimbursable plant costs.

12VAC30-90-275. Nurse Aide Training and Competency Evaluation Programs (NATCEPs) costs.

A. Facility-based NATCEPs costs.

1. Salary--staff development. Gross salary of personnel conducting the nurse aide training and competency evaluation programs.

2. Employee benefits. Benefits related to personnel conducting the nurse aide training and competency evaluation programs. See 12VAC30-90-272 B for description of employee benefits.

3. Contract services. Cost of state qualified nurse aide instructors paid on a contract basis.

4. Supplies. Cost of supplies used in conducting NATCEPs (e.g., pencils, papers, erasers, staples, textbooks and other required course materials).

5. License fees. Cost of nurse aide registry application fees and competency evaluation testing fees paid by the nursing facilities on behalf of the certified nurse aides.

6. Housekeeping expenses. Housekeeping expense as defined in 12VAC30-90-272 D, for nursing facilities which dedicate space in the facility to NATCEPs activities 100%. Housekeeping expenses shall be allocated to the NATCEPs operations in accordance with Medicare Principles of Reimbursement.

7. Maintenance and operation of plant. Maintenance and operation of plant as defined in 12VAC30-90-272 F, for nursing facilities which dedicate space in the facility to NATCEPs activities 100%.

Maintenance and operation of plant expense shall be allocated to the NATCEPs operations in accordance with Medicare Principles of Reimbursement.

8. Other direct expenses. Any other direct costs associated with the operation of the NATCEPs. There shall be no allocation of indirect patient care operating costs as defined in 12VAC30-90-272, except housekeeping and maintenance and operation of plant expenses.

B. Non-facility-based NATCEPs costs.

1. Contract services. Cost of training and competency evaluation of nurse aides paid to an outside state approved nurse aide education program.

2. Supplies. Cost of supplies of textbooks and other required course materials provided during the nurse aide education programs by the nursing facility.

3. License fees. Cost of nurse aide registry application fees and competency evaluation testing fee paid by the nursing facility on behalf of the certified nurse aides.

4. Travel. Cost for transportation provided to the nurse aides to the training or competency evaluation testing site.

12VAC30-90-276. Criminal records background checks.

Included in the Uniform Expense Classifications is the cost of obtaining criminal records checks from the Central Criminal Records Exchange for all persons hired for compensated employment after July 1, 1993.

CERTIFIED:

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Date C. Mack Brankley, Acting Director

Dept. of Medical Assistance Services

Part III

Nursing Home Payment System Appendices

Appendix II. Leasing of facilities

12VAC30-90-280. Leasing of facilities. The substance of this Appendix shall apply only to Subpart II, Article 2.

I. Determination of allowable lease costs.

A. The provisions of this Part (Appendix II) shall apply to all lease agreements, including sales and leaseback agreements and lease purchase agreements, and including whether or not such agreements are between parties which are related (as defined in 12VAC30-90-50 of the Nursing Home Payment System (NHPS)).

B. Reimbursement of lease costs pursuant to a lease between parties which are not related shall be limited to the DMAS allowable cost of ownership as determined in E. below. Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12VAC30-90-50) shall be limited to the DMAS allowable cost of ownership. Whether the lease is between parties which are or are not related, the computation of the allowable annual lease expense shall be subject to DMAS audit.

C. The DMAS allowable cost of ownership shall be determined by the historical cost of the facility to the owner of record at the date the lease becomes effective. When a lease agreement is in effect, whether during the original term or a subsequent renewal, no increase in the reimbursement shall be allowed as a result of a subsequent sale of the facility.

D. When a bona fide sale has taken place, the facility must have been held by the seller for a period of no less than five years for a lease effected subsequent to the sale date to be compared to the buyer's cost of ownership. Where the facility has been held for less than 5 years, the allowable lease cost shall be computed using the seller's historical cost.

E. Reimbursement of lease costs pursuant to a lease between parties which are not related (as defined in 12VAC30-90-50) shall be limited to the DMAS allowable cost of ownership. The following reimbursement principles shall apply to leases, other than those covered in 12VAC30-90-50 and subdivision IV (Appendix II), entered into on or after October 1, 1990:

1. An "Allowable Cost of Ownership" schedule shall be created for the lease period to compare the total lease expense to the allowable cost of ownership.

2. If the lease cost for any cost reporting period is below the cost of ownership for that period, no adjustment shall be made to the lease cost, and a "carryover credit" to the extent of the amount allowable for that period under the "Allowable Cost of Ownership" schedule shall be created but not paid.

3. If the lease cost for a future cost reporting period is greater than the "Cost of Ownership" for that period, the provider shall be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual lease cost, whichever is less. At no time during the lease period shall DMAS reimbursement exceed the actual cumulative "Cost of Ownership."

4. Once DMAS has determined the allowable cost of ownership, the provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of cost of ownership vs. lease cost to support the "carryover credit" as reported in the "Allowable Cost of Ownership" schedule, and shall submit such a schedule with each cost report.

II. Documentation of costs of ownership.

A. Leases shall provide that the lessee or DMAS shall have access to any and all documents required to establish the underlying cost of ownership.

B. In those instances where the lessor will not share this information with the lessee, the lessor can forward this information direct to DMAS for confidential review.

III. Computation of cost of ownership.

A. Before any rate determination for allowable lease costs is made, the lessee must supply a schedule comparing lease expense to the underlying cost of ownership for the life of the lease. Supporting documentation, including but not limited to, the lease and the actual cost of ownership (mortgage instruments, financial statements, purchase agreements, etc.) must be included with this schedule.

B. The underlying straight-line depreciation, interest, property taxes, insurance, and amortization of legal and commitment fees shall be used to determine the cost of ownership for comparison to the lease costs. Any cost associated with the acquisition of a lease other than those outlined herein shall not be considered allowable unless specifically approved by the Department of Medical Assistance Services.

1. Straight line depreciation.

a. Depreciation shall be computed on a straight line basis only.

b. New or additions facilities shall be depreciated in accordance with AHA Guidelines.

c. Allowable depreciation for on-going facilities shall be computed on the historical cost of the facility determined in accordance with limits on allowable building and fixed equipment cost.

d. The limits contained in 12VAC30-90-30, and Part VI (12VAC30-90-160) shall apply, as appropriate, whether the facility is newly constructed or an on-going facility.

2. Interest. Interest expense shall be limited to actual expense incurred by the owner of the facility in servicing long-term debt and shall be subject to the interest rate limitations stated in 12VAC30-90-30.

3. Taxes and insurance. Taxes are limited to actual incurred real estate and property taxes. Insurance is limited to the actual cost of mortgage insurance, fire and property liability insurance. When included in the lease as the direct responsibility of the lessee, such taxes and insurance shall not be a part of the computation of the cost of ownership.

4. Legal and commitment fees. Amortization of actual incurred closing costs paid by the owner, such as attorney's fees, recording fees, transfer taxes and service or "finance" charges from the lending institution may be included in the comparison of the cost of ownership computation. Such fees shall be subject to limitations and tests of reasonableness stated in these regulations. These costs shall be amortized over the life of the mortgage.

5. Return on Equity.

a. Return on equity will be limited to the equity of the facility's owner when determining allowable lease expense.[~~ Return on equity will be limited to 10%.~~] Return on equity shall be

equal to the rental rate percentage used in connection with the fair rental value (FRV) methodology described in Article 3.] For the purpose of determining allowable lease expense, equity will be computed in accordance with PRM-15 principles. The allowable base will be determined by monthly averaging of the annual equity balances. The base will be increased by the amount of paid up principal in a period but will be reduced by depreciation expense in that period.

b. Item 398D of the 1987 Appropriations Act (as amended), effective April 8, 1987 eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

c. [~~This elimination of return on equity capital effective July 1, 2001, applies to all computations of allowable plant or capital cost under the methodology in effect on June 30, 2000~~. Leased facilities shall be eligible for return on equity capital after July 1, 2001, only if they were receiving return on equity capital on June 30, 2000.]

IV. Leases approved prior to August 18, 1975.

A. Leases approved prior to August 18, 1975, shall have the terms of those leases honored for reimbursement throughout the duration of the lease.

B. Renewals and extensions to these leases shall be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses shall be approved.

C. Payments of rental costs for leases reimbursed pursuant to subsection A above shall be allowed whether the provider occupies the premises as a lessee, sublessee, assignee, or otherwise. Regardless of the terms of any present or future document creating a provider's tenancy or right of possession, and regardless of whether the terms thereof or the parties thereto may change from time to time, future reimbursement shall be limited to the lesser of (1) the amount actually paid by the provider, or (2) the amount reimbursable by DMAS under these regulations as of the effective date this amendment. In the event extensions or renewals are approved pursuant to subsection B of this section, no escalation clauses shall be approved or honored for reimbursement purposes.

V. Nothing in this (Appendix II) shall be construed as assuring providers that reimbursement for rental costs will continue to be reimbursable under any further revisions of or amendment to these regulations.

[12 VAC 30-90-181 to 12 VAC 30-90-300. Reserved.]

CERTIFIED:

_____ _____

Date C. Mack Brankley, Acting Director

Dept. of Medical Assistance Services