DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES DIVISION
OREGON ADMINISTRATIVE RULES

CHAPTER 411

DIVISION 70
MEDICAID NURSING FACILITIES - GENERALLY

411-070-0000 Purpose

The purpose of these rules is to control payment for Nursing Facility services provided to Medicaid clients.

411-070-0005 Definitions.

As used in OAR Chapter 411, Division 70, the definitions in OAR 411-085-0005 and the following definitions apply:

(1) "Accrual Method of Accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active Treatment" means the implementation of an individualized plan of care developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.

(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life; such as eating, dressing, bathing and personal hygiene, mobility, bowel and bladder control, and behavior.

(4) "Alternative Services" means individuals or organizations offering care to persons living in a community other than a nursing facility or hospital.

(5) "Area Agency on Aging" and "AAA" means a Type B Area Agency on Aging which is an established public agency designated under the

Older Americans Act, 42 USC 3025, and which has responsibility for local administration of Division programs.

(6) "Basic Flat Rate Payment" and "Basic Rate" mean the statewide standard payment rate for all long term care services provided to a Medicaid resident of a nursing facility except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the all-inclusive payment rate unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate).

(7) "Care Management" means observation, assessment, care planning and documentation of the resident's physical, cognitive and psycho-social needs and the supervision and coordination of the services provided to meet those needs by a licensed professional nurse.

(8) "Cash Method of Accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

(9) "Change of Ownership" means a change in the individual or legal organization which is responsible for the operation of a nursing facility. Events which change ownership include but are not limited to the following:

(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) Title to the nursing facility enterprise is transferred to another party;

(c) The nursing facility enterprise is leased or an existing lease is terminated;

(d) Where the owner is a partnership, any event occurs which dissolves the partnership;

(e) Where the owner is a corporation, it is dissolved, merges with another corporation which is the survivor, or consolidates with one or more other corporations to form a new corporation;

(f) The facility changes management via a management contract. This subsection is not intended to include changes which are merely changes in personnel, e.g., a change of administrators.

(10) "Client" means a resident for whom payment is made under the Medicaid Program.

(11) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator or other employee. They include but are not necessarily limited to the following:

(a) Salaries paid or accrued;

(b) Supplies and services provided for personal use;

(c) Compensation paid by the facility to employees for the sole benefit of the owner;

(d) Fees for consultants, directors, or any other fees paid regardless of the label;

(e) Key man life insurance;

(f) Living expenses, including those paid for related persons;

(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.

(12) "Complex Medical Add-On Payment" and "Medical Add-On" mean the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose care is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures or rehabilitation services listed in OAR 411-070-0091.

(13) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" shall mean at least once per day, five days per week.

(14) "Costs Not Related to Resident Care" means costs which are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.

(15) "Costs Related to Resident Care" means all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident care include: nursing costs, administrative costs, costs of employee pension plans, and interest expenses.

(16) "CPI" means the Consumer Price Index for all items and all urban consumers.

(17) "Developmental Disability" means severe, chronic disability which is:

(a) Attributable to cerebral palsy, epilepsy or autism, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation and requires treatment and services similar to those required for persons with mental retardation; and

(b) Manifested before the age of 22 years; and

(c) Likely to continue indefinitely; and

(d) Results in substantial functional limitations in three or more areas of major life activity; i.e., self-care, understanding and use of language, learning, mobility, self-direction and capacity for

independent living.

(18) "Direct Costs" means costs incurred to provide services required to directly meet all the resident nursing and activity of daily living care needs. These costs are further defined in these rules. Examples: The person who feeds food to the resident is directly meeting the resident's care need, but the person who cooks the food is not. The person who is trained to meet the resident's care needs incurs direct costs whereas the person providing the training is not. Costs for items which are capitalized or depreciated are excluded from this definition.

(19) "Division" means the Senior and Disabled Services Division.

(20) "DRI Index" means the "HCFA Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw - Hill in the publication Health Care Costs.

(21) "Facility" or "Nursing Facility" means an establishment which is licensed and certified by the Division as a Nursing Facility.

(22) "Facility Financial Statement" means Form SDS 35, or Form SDS 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Division for reimbursement.

(23) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(24) Generally Accepted Accounting Principles" means accounting principles currently approved by the American Institute of Certified Public Accountants.

(25) "General Assistance" means a state-funded program to assist single persons and childless couples 18 years of age and older who meet General Assistance Program criteria.

(26) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired or the excess of the price paid for an asset over its fair market value.

(27) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. It does not include "start-up costs" as defined in this rule.

(28) "Hospital-based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.

(29) "Indirect Costs" means the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). These costs are further described in OARs 411-070-0359, 411-070-0428, and 411-070-0465.

(30) "Interrupted-Service Facility" means an established facility recertified by Department of Health and Human Services or the Division following decertification.

(31) "Level of Care Determination" means an evaluation of the intensity of a client's health care needs. The level of care determination may not be used to require that the person receive services in a nursing facility.

(32) "Medical Add-On" or Complex Medical Needs Additional Payment" has the meaning provided in OAR 411-070-0027.

(33) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-IIIR) limited to schizophrenic, paranoid and schizoaffective disorders; bipolar (manic-depressive) and atypical psychosis.

(34) "Mental Retardation" means a level of retardation (mild, moderate, severe or profound) as described in the American Association on Mental Deficiencies Manual on Classification of Mental Retardation

(1983);

(35) "Necessary Costs" means costs that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. These costs are usually costs that are common and accepted occurrences in the field of long term care nursing services.

(36) "New Facility" means a nursing facility commencing to provide services to SDSD recipients.

(37) "Nursing Aide Training and Competency Evaluation Program" or NATCEP" means a nursing assistant training and competency evaluation program approved by the Oregon State Board of Nursing pursuant to ORS Chapter 678 and the rules adopted pursuant thereto.

(38) "Pediatric Rate" means the statewide standard payment rate for all long term care services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.

(39) "Pre-Admission Screening and Annual Resident Review" ("PASARR") means a process which identifies whether an individual seeking admission to or residing in a nursing facility has mental illness or mental retardation or a related condition (developmental disability); needs active treatment for the illness or disability; and if so, where the active treatment can best be provided in order to meet the needs of the individual.

(40) "Ordinary Costs" means costs incurred that are customary for the normal operation.

(41) "Oregon Medical Professional Review Organization" ("OMPRO") means the organization which determines level of care, need for care, and quality of care.

(42) "Perquisites" means privileges incidental to regular wages.

(43) "Personal Incidental Funds" means resident funds held or managed

by the licensee or other person designated by the resident on behalf of a resident.

(44) "Placement" means the location of a specific place where health care services can be adequately provided to meet the care needs.

(45) "Pre-Admission Screening" ("PAS") means an interdisciplinary assessment and decision making process which assures the most appropriate care/services for a person who is at high risk of nursing facility placement.

(46) "Provider" means an organization that has entered into an agreement with the Division to provide services for Division clients.

(47) "Reasonable Consideration" means an inducement which is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(48) "Related Organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has five percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(49) "Resident" or "Client" means those individuals for whom payment is made under the Medicaid Program.

(50) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with or direction by the donor to a specific purpose. Restricted Fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund which is to be used for general operating or building purposes.

(51) "Start-up Costs" means one-time costs incurred prior to the first resident being admitted. Start-up costs include administrative and

nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. They do not include such costs as feasibility studies, engineering studies, architect's fees or other fees which are part of the historical cost of the facility.

(52) "Supervision" means initial direction and periodic monitoring of performance. "Supervision" does not mean that the supervisor is physically present when the work is performed.

(53) "Title XVIII" and "Medicare" mean Title XVIII of the Social Security Act.

(54) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.

(55) "Uniform Chart of Accounts" means a list of account titles identified by code numbers established by the Division for providers to use in reporting their costs.

411-070-0010 <u>Conditions for Payment</u>.

Nursing Facilities must meet the following conditions in order to receive payment under Title XIX (Medicaid):

(1) CERTIFICATION.

(a) Compliance with Federal Regulations. The facility must be in compliance with Title XIX Federal certification requirements.

(b) All Beds Certified. Except as provided in Subsection (1)(c) of this rule, all beds in the nursing facility must be certified as nursing facility beds.

(c) Gradual Withdrawal. A facility choosing to discontinue compliance with Subsection (1)(b) of this rule, may elect to gradually withdraw from Medicaid certification, but must comply with all of the following:

(A) Notify the Division in writing within 30 days of the certification survey that it elects to gradually withdraw from the Medicaid Program.

(B) Request Medicaid reimbursement for any resident who resided in the facility, or who was eligible for right of return or right of readmission under OAR 411-088-0050 or 411-088-0060, on the date of the notice required by Subsection (1)(c) of this rule. If it appears the resident may be eligible within 90 days, such request shall be initiated.

(C) Retain certification for any bed occupied by or held for any resident who is found eligible for Medicaid, until the bed is vacated by:

(i) The death of the resident; or

(ii) The transfer or discharge of the resident, pursuant to the Nursing Facility Transfer Rules (OAR Chapter 411, Division 88).

(D) All Medicaid recipients exercising rights of return or readmission under the transfer rules must be permitted to occupy a Medicaid certified bed.

(E) Notify in writing all persons applying for admission subsequent to notification of gradual withdrawal that, should the person later become eligible for Medicaid assistance, that reimbursement would not be available in that facility.

(2) CIVIL RIGHTS, MEDICAID DISCRIMINATION.

(a) The facility shall meet the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(b) The facility shall not discriminate based on source of payment.

The facility shall not have different standards of transfer or discharge for Medicaid residents except as required to comply with this rule.

(c) The facility shall accept Medicaid payment as payment in full. The facility shall not require, solicit or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a "responsible party."

(d) No applicant shall be denied admission to a facility solely because no family member, relative or friend is willing to accept personal financial liability for any of the facility's charges.

(e) The facility shall not request or require a resident, relative or "responsible party" to waive or forego any rights or remedies provided under state or federal law, rule or regulation.

(3) PROVIDER AGREEMENT, FACILITY PAYMENT

(a) The facility shall sign a formal provider agreement with the Division.

(b) The facility shall file a Facility Financial Statement with the Division within 90 days after the end of its fiscal year.

(c) The facility shall bill the Division in accordance with established rules and guidelines.

411-070-0015 Denial, Termination or Non-Renewal of Provider Agreement

(1) FAILURE TO COMPLY. The Division reserves the right to deny, terminate or not renew contracts with providers who fail to comply with OAR 411-070-0000 through 411-070-0465 relating to nursing facility services.

(2) NOTICE. The Division will give the provider 30 day's written notice, by Certified Mail, before the effective date of the denial, termination or non-renewal. The notice will include the basis of the Division's decision, advise the provider of the right to an informal conference to give the opportunity to refute the Division's findings in writing.

(3) INFORMAL CONFERENCE.

(a) A request for an informal conference must be received by the Division prior to the effective date of the denial, termination or non-renewal.

(b) A written notice of the Division's decision reached in an informal conference will be sent to the provider by Certified Mail. This notice will also advise the provider of his/her right to a hearing, if requested within 30 days of mailing the notice.

(4) HEARING. When a hearing is requested, it will be conducted in accordance with OAR 411-001-0010.

411-070-0020 <u>On-Site Reviews</u>

The facility shall allow periodic on-site reviews of Medicaid residents as required by Federal regulations.

411-070-0022 <u>NF Payment Category 1</u> - REPEALED 7/1/97

411-070-0025 <u>Basic Flat Rate Payment (Basic Rate)</u>

(1) PAYMENT. The Division may authorize payment at the basic rate if a Medicaid client requires daily, intermittent licensed nurse observation and continuous nursing care and has a physician's order for nursing facility care. When determining the payment rate, the Division will consider the stability of the medical condition, the health care needs of the client, and the client's ability to maintain him/her self in a less restrictive setting. A client who qualifies for reimbursement at the basic rate will:

(a) Have chronic medical problems which are stabilized but not cured and a need for supervision in a structured environment to maintain or restore stability and prevent deterioration; or

(b) Require assistance for a combination of health care needs either because of a physical or psycho-social disabling condition; or

(c) Have insufficient personal and community resources available to provide for either subsection (1)(a) or (b) of this rule.

(2) DOCUMENTATION. The professional nursing staff of the nursing facility shall keep sufficient documentation in the resident's clinic record to justify the basic rate payment determination in accordance with these rules and shall make it available to the Division upon request.

411-070-0026 NF Payment Category 3 - REPEALED 7/1/97

411-070-0027 Complex Medical Needs Additional Payment (Medical Add-On)

(1) PAYMENT. The Division may authorize payment for a medical add-on (in addition to the basic rate) when the client requires one or more of the treatments, procedures and services listed in OAR 411-070-0091.

(2) AUTHORIZATION.

(a) Initial Approval - Approval of the medical add-on must be obtained from the Pre-Admission Screener prior to placement in the nursing facility.

(b) Continued Payment - The Division shall continue to pay the medical add-on only as long as warranted by the condition of the client.

(3) DOCUMENTATION. The professional nursing staff of the nursing facility shall keep sufficient documentation in the resident's clinical

record to justify the medical add-on payment determination in accordance with these rules and shall make it available to the Division upon request.

411-070-0029 Pediatric Rate

(1) This rate will be for those facilities meeting the criteria established in OAR 411-070-0452 as Pediatric Nursing Facilities or as self-contained pediatric units.

(2) The pediatric rate shall constitute the total rate payable by the Division on behalf of its client.

411-070-0030 NF Payment Category 5 - REPEALED 7/1/97

411-070-0035 Placement, Payment Authorization and Administrative Review

(1) PRIOR AUTHORIZATION. The Division shall reimburse a nursing facility for services provided to a Division client only if prior authorized after the Division has participated in development of the placement plan and is satisfied that the placement is justified and most suitable for the person according to the Division's service plan. The Division shall not reimburse a nursing facility for services rendered prior to the date of referral to the Division. A nursing facility shall verify that the local SDSD Unit/Type B AAA where the facility is located is involved in the placement.

(a) Initial Level. Initial determination of resident level shall be made by the Preadmission Screener.

(b) Adjustments. The facility shall notify the Division's Resident Care Review Specialist according to the Division schedule for weekly reporting, (excluding weekends, state holidays and any business day on which the offices of the State of Oregon are closed by the Governor or his/her designee) of:

(A) Admission of any Medicaid client whose condition and/or

care needs meet the criteria for the medical add-on and has had a Pre-Admission Screening that reflects the same;

(B) An in-facility Medicaid resident whose condition and/or care needs change and now meets the criteria for the medical add-on; and

(C) Termination of the medical add-on for a resident whose condition and/or care needs no longer meet the criteria for the medical add-on.

(c) Payment Effective Dates and Notification Requirements.

(A) For a new resident of a nursing facility, the medical add-on approved by the Preadmission Screener is effective from the date of admission to the last date on which the resident meets the medical add-on criteria. The nursing facility shall add these residents to the next weekly report filed after admission. However, if the nursing facility fails to add the resident to the report or files the report more than two working days after it is due, the Division shall pay the medical add-on from the date of notification only.

(B) For an in-facility resident whose condition and/or care needs change, the medical add-on is effective from the date the resident meets the medical add-on criteria to the last date the resident meets the medical add-on criteria. The nursing facility shall add these residents to the next weekly report filed after the resident meets the medical add-on criteria. However, if the nursing facility fails to add the resident to the report or files the report more than two working days after it is due, the Division shall pay the medical add-on from the date of notification only.

(C) Notwithstanding paragraphs (1)(c)(B) of this rule, for an in-facility resident whose condition and/or care needs change is an emergent medical/surgical problem or an emergent behavior problem, the medical add-on is effective from the

date of the change to the last date the resident meets the medical add-on criteria. The nursing facility shall notify the Resident Care Review Specialist the next working day or within two days following the emergent problem. However, if the nursing facility fails to notify the Division in a timely manner, the Division shall pay the medical add-on from the date of notification only.

(2) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of the Division's Resident Care Review Specialist to make or deny an adjustment in the medical add-on payment for a Medicaid resident, the provider may request from the Division an administrative review of the decision. The provider shall submit its request for review in writing within 30 days of receipt of the notice to make or deny the adjustment. The provider shall submit documentation, as requested by the Division, to substantiate its position. The Division shall notify the provider in writing of its informal decision within 45 days of the Division's receipt of the provider's request for review. The Division's informal decision will be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(3) MEDICAL ADD-ONS PROHIBITED. The Division will not provide medical add-on payments for residents placed in a facility having a waiver which allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

(4) CONFIRMATION OF SDSD RESPONSIBILITY. Receipt of Form SDS 458A (or equivalent form), Financial Planning for Medicaid Nursing Facilities/Institutions, from the local SDSD Unit/Type B AAA will acknowledge and detail the Division's payment responsibility for nursing care of the resident. Form SDS 458A also details the resident's income sources which make up client liability. The facility is responsible for collecting client liability from the resident or their responsible party.

(5) REDUCED PAYMENT FOR ABUSE.

(a) If abuse of a resident, according to the provisions of ORS

441.630 to 441.700, is substantiated by the Division, the Division may reduce the payment for the client(s) for the month the abuse occurred, and until such time as the Division determines the conditions leading to the abuse have been corrected.

(A) The facility shall receive payment for care provided the client as determined by the Division. This determination shall be based on the absence of appropriate care, which resulted in the substantiated abuse of a resident;

(B) The reduced payment shall not be considered a reduction in benefits for the client.

(b) The Division shall notify the facility by certified mail at least fifteen days prior to taking action to reduce payment.

(A) The notice shall include the basis of the Division's decision, the effective date of the reduced payment, the amount of the reduced payment, and shall advise the facility of their right to request review by the Administrator if such request is made in writing within 30 days of the receipt of the notice;

(B) If a request for review is made, the Administrator shall review all material relating to the allegation of resident abuse and to the reduction in payment. The Administrator shall determine, based upon review of the material, whether or not to sustain the decision to reduce payments to the facility and shall notify the facility of the decision within 20 days of receiving the request for review;

(C) If the Administrator determines not to sustain the decision to reduce payments, the reduction shall be lifted immediately. Otherwise, the reduction in payment shall remain in effect until the Division determines the conditions leading to the abuse have been corrected;

(D) If the decision to reduce payment is sustained, the payment reduction will not be recovered in the year end

settlement.

(6) OVERPAYMENT FOR MEDICAL ADD-ONS. The Division shall collect monies that were overpaid to a facility for any period during which the Division determines the client did not meet the criteria for the medical add-on.

411-070-0040 Client Screening, Assessment and Review

(1) Pre-Admission Screening (PAS)

Pre-Admission Screening is an on-site assessment of an individual's health, functional, psycho-social, and economic status. The on-site assessment is conducted to establish the most appropriate placement/services for persons who are requesting or who are being referred for nursing facility placement. PAS is available to any person upon request or referral and is provided without regard to income. PAS is mandatory for all requests or referrals for nursing home placement which involve payment for nursing facility care by the Division. No payment for nursing facility care will be authorized by the Division until Pre-Admission Screening has established that it is the most appropriate service for the client. PAS must first assess Title XIX and GA eligibles for those who will be Title XIX or GA eligible upon admission to a nursing facility. Other persons will be assessed as time will allow.

(2) Client Review

(a) Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by Oregon Foundation of Medical Care (OFMC) meet these requirements.

(b) Staff associated with SSD are required to maintain service plans on all Division clients in nursing facilities. The frequency of their service plan update will vary depending on such factors as resident's potential for relocation and federal or state requirements for resident review.

(c) Authorized representatives of the Division and/or OFMC shall have immediate access to Division residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care or alleged abuse. The Division and/or OFMC representative shall be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities.

(d) Division and/or OFMC representatives shall have the right to privately interview any Division's residents and any facility staff in carrying out the above responsibilities.

(e) Division and/or OFMC representatives shall have the right to participate in facility staffings on Division residents.

411-070-0043 <u>Pre-Admission Screening and Resident Review (PASRR)</u>

(1) <u>Introduction</u>

(a) The purpose of PASRR is to prevent the placement of individuals with mental illness (MI) or mental retardation/developmental disabilities (MR/DD) in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, Subparts C through E.

(b) PASRR is a process of evaluating Medicaid certified nursing facility potential or current residents with indicators of MI or MR/DD to determine if the nursing facility is appropriate to meet their needs and if specialized mental health or MR/DD services are needed. PASRR includes three components:

(A) Level I initial screenings prior to nursing facility admission

to determine if there are indicators of MI or MR/DD that require further evaluation, and if nursing facility placement is appropriate;

(B) As needed, Level II comprehensive assessments and determinations by Mental Health and Developmental Disability Services Division (MHDDSD) of individuals with MI or MR/DD to evaluate and determine whether Specialized Services should be obtained in another setting;

(C) Individuals already residing in nursing facilities should be referred to the Office of Mental Health Services for a Level II evaluation based on symptomatic changes in mental health condition. Individuals identified as having MR/DD through the Level I screening are reviewed by the Office of Developmental Disability Services.

(2) Definitions

(a) "Area Agency On Aging (AAA)" means the agency designated by the Senior and Disabled Services Division (SDSD) and charged with the responsibility of providing a comprehensive and coordinated system of services to the elderly in a planning and service area.

(b) "Categorical Determinations" means the four categories of persons with indicators of MI or MR/DD who may enter a nursing facility without a Level II evaluation:

(A) Individuals admitted to a nursing facility from an acute care hospital for recovery from an illness or surgery and stay is not to exceed 30 days (60 days if MR/DD);

(B) Individuals certified terminally ill (prognosis of life expectancy of 30 days or less);

(C) Individuals needing nursing facility services for length of stay of 30 days or less for respite for in-home care givers;

or

(D) Individuals with severe chronic medical condition or illness that precludes participation in, or benefit from, Specialized Services.

(c) "Certified Program" means a hospital, private agency or an area agency on aging certified by the Division to conduct Private Admission Assessments in accordance with ORS 410.530.

(d) "Developmental Disability" means a diagnosis of developmental disability with onset before age 22. Conditions/syndromes associated with developmental disabilities may include autism, cerebral palsy, seizure disorder, degenerative neurological disorders, Sanfilippo, Prader Willi, deLange or Down. In addition, the individual must manifest substantial limitations as a result of the conditions/syndromes in three or more of the following: self care, self direction, language, mobility, capacity for independent living, learning.

(e) "Division" means the Senior and Disabled Services Division of the Department of Human Resources.

(f) "Exempted Hospital Discharge" for pre-admission screening means an individual seeking temporary admission to a nursing facility from a hospital and is certified by the attending physician to meet all of the criteria. The criteria are:

(A) Seeks admission directly from a hospital after receiving acute inpatient care at the hospital;

(B) Requires nursing facility services for the condition for which he/she received care in the hospital; and

(C) Requires nursing facility services for 30 days or less.

(g) "Level I" means the pre-admission screening and assessment process implemented by the Division to identify individuals with

indicators of MI or MR/DD and determine their need for nursing facility services.

(h) "Level II" means a comprehensive assessment implemented by MHDDSD of individuals with MI or MR/DD to evaluate and determine whether nursing facility services and Special Services are needed.

(i) "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizo-affective disorders and/or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimers are excluded.

(j) "Mental Retardation" means a diagnosis of mental retardation with onset before age 18 and documented with I.Q. Score below 70 plus clinical observation.

(k) "New Admission" for pre-admission screening means an individual admitted to any nursing facility for the first time and is not an exempted hospital discharge.

(l) "Nursing Facility" means a facility licensed to provide nursing care. Unless indicated otherwise, "nursing facility" means a Medicaid certified nursing facility.

(m) "Pre-Admission Screening" means the screening of individuals prior to admission to a nursing facility to identify individuals with MI or MR/DD and determine their need for nursing facility services.

(n) "Resident Review" means a review conducted by MHDDSD of individuals with MI or MR/DD who are residents of nursing facilities to determine whether the individual requires the level of services provided by the nursing facility and whether the individual requires Specialized Services.

(o) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.

(p) "Specialized Services for Mental Retardation/Developmental Disability" means

(A) A continuous program of specialized and generic training, treatment, and activities directed toward:

(i) The acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible;

(ii) Prevention (or deceleration) of regression or loss of current optimal functional status;

(iii) Increased interaction with other persons both within and outside the nursing facility;

(iv) Increased access to, and participation in, community events and activities, including as appropriate, employment; and

(v) Enhancement of the individual's quality of life.

(B) Emphasis is placed on providing Specialized Services at sites outside the nursing facility. By doing so, the individual learns new skills and behaviors in more normalized environments with natural supports and consequences. Further, community settings provide increased opportunities for social and physical integration.

(3) Pre-Admission Screening (PASRR Level I)

A pre-admission screening for indicators of serious MI or MR/DD and appropriateness of placement shall be provided prior to admission for all individuals applying as new admissions to a Medicaid certified

nursing facility regardless of the individual's sources of payment.

(a) Medicaid Eligible Individuals

(A) Completion of the Pre-Admission Screening. Except as provided in Subsection (3)(a)(B) of this rule, the pre-admission screening shall be completed in conjunction with the Client Assessment and Planning System by approved Pre-Admission Screening personnel from the local AAA/SDSD unit.

(B) Exception. The local AAA/SDSD unit may delegate, in writing, completion of the PASRR Level I form to a Certified Program if the individual to be screened is a current Medicaid client being discharged from an acute care hospital to a Medicare certified nursing facility.

(C) Pre-Admission Screening Form. The pre-admission screening shall be completed using the designated Level I Pre-Admission Screening form.

(D) Completion of the PASRR Level I form under Subsection (3)(a)(B) of this rule does not constitute prior authorization of payment. Nursing facilities shall still obtain prior authorization from the local AAA/SDSD unit as required in OAR 411-070-0035.

(b) Non-Medicaid Eligible Individuals. For non-Medicaid eligible individuals, the pre-admission screening shall be completed in accordance with the Private Admission Assessment Program established by ORS 410.505 through 410.545 and OAR Chapter 411, Division 071.

(c) Negative Response To Pre-Admission Screening. If there are no indicators of MI or MR/DD or if the individual belongs to a categorically exempt group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(d) Mental Illness Indicators. If there are indicators of mental illness, the individual shall not be admitted to a nursing facility without a referral to the Office of Mental Health Services for a Level II evaluation. If the individual demonstrates a need for nursing facility services as determined by membership in a categorical determination group, then the individual may be admitted without the Level II evaluation prior to admission.

(e) Mental Retardation/Developmental Disability Indicators. If there are indicators of mental retardation/developmental disability, the individual shall be referred to the Office of Developmental Disability Services (ODDS) for possible Level II Evaluation. Prior to admission of the individual to a nursing facility, the ODDS must be contacted to seek a waiver of OAR 309-048-0020 which prohibits placement of persons with mental retardation/developmental disabilities in nursing facilities. Based on the functional assessment portion of the pre-admission screening, the screener shall make a recommendation as to the individual's need for services.

(f) Pre-Admission Screening Form Requirement. Except as provided in Subsection (3)(g) of this rule, nursing facilities shall not admit an individual without a completed and signed pre-admission screening form in the client record.

(g) Exception To Form Requirement. A nursing facility may admit an individual without a completed and signed pre-admission screening form in the client record provided the facility has received verbal confirmation from the screener that the screening has been completed and a copy of the screening will be sent to the facility as soon as is reasonably possible.

(h) Recordkeeping. The original or a copy of the pre-admission screening form shall be retained as a permanent part of the individual’s clinical record and must accompany the individual if he/she leaves the facility.

(4) Resident Review

(a) Mental Illness. All residents of a Medicaid certified nursing facility shall be referred when symptoms of mental illness develop.

(A) Completion of the Resident Review Part A will be completed by the nursing facility.

(B) Referral. Resident reviews with indicators of mental illness and which require further evaluation shall be referred to the local Community Mental Health Program who will determine eligibility for Level II evaluations.

(C) Form. The resident review shall be performed in conjunction with the Comprehensive Assessment Form specified by the Division (see OAR 411-086-0060) using forms designated by MHDDSD.

(b) Mental Retardation/Developmental Disability. Residents identified as having mental retardation/developmental disabilities through the pre-admission screening process shall be reviewed at least annually, or as dictated by changes in residents' needs/desires, by the local county mental retardation/developmental disability authority and the Office of Developmental Disability Services.

(A) Completion of the Resident Review. The resident review shall be completed by the local county mental retardation/developmental disability authority and the Office of Developmental Disability Services.

(B) Form. The resident review shall be completed using forms designated by the Office of Developmental Disability Services.

(5) PASRR Level II Evaluations and Determinations

(a) Referral. Whenever the pre-admission screening process as established in Section (3) of this rule or the resident review process as established in Section (4) of this rule identifies a need for a PASRR Level II Evaluation and Determination, the individual shall be referred to the appropriate office of MHDDSD.

(b) Evaluation Standards. Evaluations shall be conducted under standards and criteria established by MHDDSD.

(c) Determinations. Determinations shall be consistent with Federal Regulations established by the Health Care Financing Administration according to Section 1919(e)(7)(C) of the Social Security Act.

411-070-0045 Facility Payments

(1) PAYMENT TO PROVIDER. Provider payments will be made following the month of service. For billing, Adult and Family Services Division will mail Form SDS-483, Invoice and Payment Authorization, to each facility.

(2) RESIDENT'S INCOME. A resident's income, exclusive of the authorized allowance for personal incidental needs and other prior authorized special needs, will be offset as a credit against the established Division rate paid to that facility.

411-070-0050 Days Chargeable

The Division will pay for the day of admission but not for the day of discharge, transfer, or death except as provided for in Rule 411-070-0110. When the day of admission is the same as the day of discharge, the Division shall pay for one day.

411-070-0075 Rates--Facilities in Oregon

The daily rate of payment for Oregon facilities will be the basic rate plus the medical add-on, if determined to be appropriate, or the pediatric rate, if warranted.

411-070-0080 Out-of-State Rates

Out-of-state facilities in areas contiguous to Oregon will be paid for Division clients who are receiving temporary care while alternative placement in Oregon is being located. Payment will be made at the facility's Medicaid rate established by the state in which the facility is located or the maximum rate paid to Oregon nursing facilities for a comparable payment level, whichever is less. The maximum rate for out-of-state purposes is Oregon's basic rate plus the medical add-on, if determined to be appropriate, or the pediatric rate, if warranted. The facility will file Form AFS 716, Medical Provider Certification, certifying its Medicaid rates and compliance with the Civil Rights Act of 1964. An Oregon resident will be returned to Oregon when proper placement can be made and it is feasible to do so.

411-070-0085 All-Inclusive Rate

(1) PURPOSE.

The nursing facility rate established for a facility shall be an all-inclusive rate and is intended to include all services, supplies and facility equipment required for care except therapy services, supply item(s) or equipment covered under OAR 411-070-0359(3) (Third-Party Payors).

(2) SERVICES and SUPPLIES.

(a) The following services and supplies required to provide care in accordance with each resident's care plan are included in the all-inclusive rate, except as modified by OAR 411-070-0359(3):

(A) All nursing and support services and supplies including restorative services, incontinency care, feeding, and routine foot care;

(B) Activities and social services programs and supplies;

(C) Professional consultation required for licensing or certification;

(D) Management of personal incidental funds, including purchase of items;

(E) Special diets and non-pumped food supplements;

(F) Room and board;

(G) Laundry, whether performed by the facility staff or an outside provider. This service includes laundry and marking of resident's personal clothing and bedding;

(H) Items stocked by the facility in gross supply and administered individually on physician's order;

(I) Items owned or rented by the facility which are utilized by individual residents but which are reusable and are routinely expected to be available in a nursing facility;

(J) Shaves, haircuts, and shampoos as required regularly for grooming and cleanliness, whether performed by facility staff or outside providers;

(K) Basic grooming supplies;

(L) Transportation provided in facility vehicles;

(M) All oxygen and oxygen equipment, including concentrators, unless the oxygen provided exceeds 1,000 liters per day;

(N) If allowed under OAR 411-070-0359, therapy services provided by on-staff therapists;

(O) All administrative functions of the facility Medical Director.

(b) The following services and supplies are NOT included in the all-inclusive rate:

(A) Therapy services provided to residents by outside

providers;

(B) Medical services by physicians or other practitioners, radiology services, laboratory services and podiatry services;

(C) Transportation for residents to and from medical care in non-facility vehicles;

(D) Biologicals (eg., immunization vaccines), hyperalimentation (eg., nutritional therapy consisting of vitamins, glucose, electrolytes, minerals etc., to sustain life), over-the-counter and prescription pharmaceuticals;

(E) Ventilators.

(3) EXAMPLES. The all-inclusive rate established for the facility includes but is NOT limited to the following items, except as modified by OAR 411-070-0359(3), whether routinely stocked or specially purchased:

Air mattresses, egg carton mattresses
Airway, oral
Alternating pressure pads and pumps
Applicators, cotton tipped
Aquamatic K pads (water-heated pad)
Arm slings
Band Aids
Bandages, including elastic or cohesive
Basins
Bath/Shower benches and chairs
Bed frame equipment (for certain immobilized bed confined residents)
Bedpan, regular and fracture
Bed rails
Bibs, including plastic
Canes
Catheter, urinary (any size, including indwelling)
Catheter bags, plugs and tray
Clinitest tablets
Colon tubes
Combs, brushes
Commode chairs
Communication boards
Cotton and cottonballs
Creams (i.e., A & D, Eucerin, etc.)
Crutches
Decubitus ulcer pads, preventive items
Deodorants, room
Diabetic urine testing (i.e., Clinitest, Diastix)
Disposable underpads, diapers
Douche bags
Drainage bags, sets, tubes
Dressings (all, including surgical and dressing tray, pads, tape, sponges, swabs, etc.)
Enemas and enema supplies, OTC
Eye pads
Feeding tubes and units, gastric, nasal (non-pumped)
First aid supplies
Flotation mattress, pads and/or turning frames
Folding foot cradle
Food or food supplements provided between meals for nourishment
Footboards
Gauze and gauze sponges
Geriatric chairs
Gloves, unsterile and sterile, examination and surgical
Glucose monitors
Gowns, hospital
Heat cradle, heat pads
Hot pack machine
Hot water bottles

Ice bags
Incontinency care and supplies, pants, diapers
Infusion arm boards
Inhalation therapy supplies
Nebulizer and replacement kit
Steam vaporizer
Intermittent positive pressure breathing apparatus (I.P.P.B.)
Invalid ring
Irrigation bulbs and trays
I.V. trays and tubing
Jelly, lubricating
Lamps, infrared and ultraviolet
Laxative, OTC
Linens
Lotions, creams, and oils, over-the-counter (i.e., Keri, Lubriderm, etc.)
Medicine dropper
Menstrual supplies
Nasal cannula
Nasal catheter
Needles (various sizes)
Ointments (i.e., Neosporin, Vaseline)
Ostomy Bags and Supplies
Overhead trapeze equipment
Oxygen (See 410-122-200)
Oxygen tents, masks, etc.
Padding for incontinent care
Pumps, aspiration and suction
Restraints
Rubber rings
Sand bags
Shampoo, including medicated shampoos, conditioners
Sheepskin
Soap, including medicated
Specimen cups and bottles
Stomach tubes
Suction equipment and machines
Syringes (all sizes) reusable and disposable
Tes-Tapes
Thermometers
Tissues, bedside and toilet
Tongue depressors
Toothbrushes and paste
Traction equipment
Tuberculin tests
Urinals, male and female
Urological solutions
Walkers
Water bed
Water pitchers
Wheelchairs--(non-customized)

411-070-0090 Payment for Medical Care and Services - REPEALED

411-070-0091 Complex Medical Add-On Services

(1) PROFESSIONAL NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and has a documented need for one or more of the procedures, routines or services listed in subsections (a) to (c) of this rule, the Division shall pay a complex medical add-on payment (in addition to the basic rate) for services.

(a) Medication Procedures

(A) Administration of medication(s) requiring skilled observation and/or judgment for necessity, dosage and/or effect, for example pain management, new anticoagulants, etc. (This category does not cover routine or oral medications or the use of oral antibiotics or the infrequent adjustments of current medications). Documentation required is a daily nursing note. Residents are eligible for add-on while procedures are daily or more often.

(B) Intravenous injections/infusions, heparin locks used daily or continuously for hydration or medication. Documentation required is a daily nursing note. Daily total parenteral nutrition (TPN) may be documented on a flowsheet with a weekly nursing note.

(C) Intramuscular medications for unstable condition used at least daily. Documentation required is a daily nursing note.

(D) External infusion pumps used at least daily if resident cannot self-bolus. Documentation required is a daily nursing note.

(E) Hypodermoclysis - daily or continuous use. Documentation required is a daily nursing note.

(F) Peritoneal dialysis, daily, when resident unable to do own exchanges. Documentation required is a daily nursing note.

(b) Treatment Procedures

(A) Nasogastric, gastrostomy/jejunostomy tubes used daily for feedings. Daily information may be documentation on a flowsheet with a weekly nursing note.

(B) Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, in resident who is dependent on nursing staff to maintain airway. Documentation required is a daily nursing note.

(C) Percussion, postural drainage, and aerosol treatment when all three performed twice per day or more. Documentation required is a daily nursing note.

(D) Ventilator dependence. Care and services for resident who is dependent on nursing staff for initiation, monitoring, and maintenance. Documentation required is a daily nursing note.

(c) Skin/Wound

(A) Stage III or IV decubitus ulcers, or ulcers related to circulatory impairment, that are being aggressively treated with expectation of resolution. Initial documentation required is completion of Rap 16 from the MDS (Minimum Data Set) form. Follow-up documentation is a weekly wound assessment and nursing note.

(B) Open wound(s) which require aggressive treatment and are expected to resolve. Documentation required is a weekly assessment and nursing note.

(C) Deep or infected stasis ulcers with tissue destruction equivalent to Stage III. Eligible for add-on until resolved or returned to previous chronic status. Documentation required is a weekly assessment and nursing note.

(d) Insulin Dependent Diabetes Mellitus (IDDM)

(A) Unstable Insulin Dependent Diabetes Mellitus (IDDM) in a

resident who requires sliding scale insulin and

(i) Exhibits signs/symptoms of hypoglycemia and/or hyperglycemia; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) Documentation required is a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions, is not considered unstable.

(e) Other

(A) Professional Teaching. Short term, daily teaching pursuant to discharge or self-care plan. Documentation required is a teaching plan with weekly progress notes.

(B) Emergent medical/surgical problems, requiring short term professional nursing observation and/or assessment. Payment for the add-on requires authorization from the Resident Care Review Specialist. Faxed documentation of the emergent problem will be requested. Eligibility for the add-on will be until the resident no longer requires professional observation and assessment for this medical/surgical problem. Documentation required is a nursing note each shift.

(C) Emergent Behavior Problems - Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and a care plan.

Payment for the add-on requires authorization from the Resident Care Review Specialist. Faxed documentation of the emergent behavior problem will be requested. Eligibility for the add-on will be until the resident no longer requires professional observation and assessment for this medical problem. Documentation required is a nursing note each shift.

(2) REHABILITATION SERVICES

(a) Physical Therapy - at least 5 days every week.

(b) Speech Therapy - at least 5 days every week.

(c) Occupational Therapy - at least 5 days every week.

(d) Any combination of physical therapy, occupational therapy, and speech therapy at least 5 days every week qualifies. Documentation required is the therapist's notes and a weekly nursing progress note related to the rehabilitation services(s) being provided.

(e) Respiratory Therapy - at least 5 days every week by respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor. Documentation required is the therapist's notes and weekly nursing progress note.

411-070-0095 <u>Personal Incidental Funds</u>

(1) Each Medicaid and General Assistance resident is allowed a monthly amount for personal incidental needs. For purposes of this rule, personal incidental funds include monthly payments as allowed and previously accumulated resident savings.

(2) FACILITY RESPONSIBILITY. The facility shall assure that residents for whom the nursing facility is holding, managing, spending, or disbursing personal incidental funds (PIFs) have such funds managed in the resident's own best interest; that neither PIFs nor funds from family/friends be used for services, supplies and equipment included in the facility's all-inclusive rate; or for items for which reimbursement

through another source is available.

(a) The facility shall not charge for items included in the all-inclusive rate or for other items or services for which funding can be provided through the Medicaid agency or another non-resident source.

(b) The facility shall hold, safeguard and account for a resident's personal incidental funds if he/she requests such management; or if the case manager requests on Form SDS 542 that the facility perform such management.

(c) The facility shall maintain a record of the request by the resident, case manager or resident representative on Form SDS 542, covering all funds it holds or manages for residents.

(d) The facility shall manage resident funds in a manner in the resident's best interest.

(A) The facility shall not charge the resident for holding, disbursing, safeguarding, accounting for, or purchasing from personal incidental funds. Charges for these services are included in the Nursing Facility Financial Statement, Form SDS 35 or SDS 35A, and are considered allowable costs reimbursable through the all-inclusive rate.

(B) The cost for items charged to personal incidental funds shall not be more than the actual purchase price charged by an unrelated supplier.

(C) The facility may not charge Division clients or other sources for items or services furnished if all residents receiving such items or services are not charged. Charges shall be for direct, identifiable services or supplies furnished individual residents. A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges shall be made only after services are performed or items are delivered.

(D) The facility shall keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's

funds.

(E) The nursing facility may request technical assistance from SDSD/Type B AAA staff, however, responsibility for managing resident funds in the resident's best interest remains with the facility.

(F) When a facility is a resident's representative payee, it must fulfill its duties as representative payee in accordance with applicable federal regulations and state regulations which define those duties.

(G) Facilities holding resident funds must be insured to cover all amounts held in trust.

(3) DELEGATION OF PIF AUTHORITY.

(a) The resident may manage his/her personal financial resources, including PIFs, and may authorize another person or the facility to manage them. The facility must, upon written authorization by the resident or representative, or case manager on the client's behalf, if appropriate, accept responsibility for holding, safeguarding, spending and accounting for these funds.

(b) At the time of admission, the facility shall assure that the resident or representative delegating such responsibility to the facility completes Form SDS 542, Designation of Management of Personal Incidental Funds, and the facility will sign the form acknowledging responsibility. The facility will retain the original in the resident's personal incidental fund records, with copies to the resident and the Division.

(c) The resident wishing to change delegation shall do so by completing a new SDS Form 542, which shall be available at the facility.

(d) The Division cannot be delegated to account for the resident's personal incidental funds.

(4) RESIDENT ADMISSION.

(a) The facility shall provide each resident and/or resident representative with a written statement at the time of admission that:

(A) States the facility's responsibility to pay for all services, supplies, and facility equipment required for care (basic rate);

(B) Lists all services provided by the facility which are not included in the facility's basic rate;

(C) States that there is no obligation for the resident to deposit funds with the facility;

(D) Describes the resident's right to select how personal funds will be handled. The following alternatives must be included:

(i) The resident's right to receive, retain, and manage his or her personal funds or have this done by a legal guardian, or conservator;

(ii) The resident's right to delegate on the SDS 542 another person to act for the purpose of managing his or her personal funds; and

(iii) The facility's obligation, upon written authorization by the resident or representative, to hold, safeguard and account for the resident's personal funds in accordance with these rules.

(E) States that any facility charge for this service is included in the facility's basic rate, and that the facility cannot charge for PIF management or charge residents more than the actual purchase price of items at an unrelated supplier.

(F) States that the facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee;

(G) States that if the resident becomes incapable of managing his or her personal funds and does not have a representative, the facility is required to manage his or her personal funds if requested on Form SDS 542 by the case manager.

(b) The facility shall obtain documentation on Form SDS 542 of resident intention to manage own funds, or resident, resident representative, or case manager delegation to another individual or the facility.

(5) RESIDENT RIGHTS.

(a) The resident must be allowed to manage his/her own funds, or to delegate their management to another, unless the resident has been determined to be incompetent by a court of law. A resident who was not adjudicated incompetent may always decide how to spend his/her own funds. Facility staff delegated to manage PIFs shall follow guidelines outlined in this rule and other state and federal laws and regulations which may apply in order to assure that decisions not made by the resident are made in his/her best interest.

(b) The facility shall not solicit resident or family/friends to purchase items included in the facility's daily rate.

(c) The facility shall not charge resident PIFs for any item included in the facility's daily rate unless it can show at least one of the following:

(A) The resident made an informed decision to purchase the item, understanding that a similar and appropriate item is included in the daily rate; or

(B) The family requested that the facility purchase the item, understanding that a similar and appropriate item is included in the daily rate; or

(C) The resident is not currently able to make an informed decision to purchase the item, but did so prior to current incapacity.

(d) The facility shall not charge the resident or family/friends for any drug

designated by the Food and Drug Administration as less-than-effective unless it can show that both the physician and the resident made an informed decision to continue use of the drug.

(e) Prior to purchasing an item which is included in the facility's daily rate or is over $50, the facility shall consult with the SDSD/Type B AAA case manager.

(f) The facility shall not charge resident PIFs for any item or service which benefits the facility, facility staff or relatives or friends of facility staff, unless it can show that the resident made an informed decision to purchase the item or service.

(g) When the facility or SDSD is of the opinion that a resident is incapable of managing personal funds and the resident has no representative, the facility shall refer the resident to the case manager in the local SDSD unit/Type B AAA, who will consult with the resident regarding resident preference. If the attending physician agrees, as documented on Form SDS 544, Physician's Statement of Client's Capacity to Manage Funds, that the resident is incapable of handling funds, the case manager will attempt to find a suitable delegate to manage the resident's funds. If no delegate can be found, the facility shall assume the responsibility. If the resident disagrees with the designation of a delegate, the designation cannot be made, and the client retains the right to manage, delegate, and direct use of his own money, if not adjudicated incompetent.

(6) DEATH OF RESIDENT.

(a) Resident Account Records

(A) The facility will maintain a Resident Account Record (Form SDS 713), on an ongoing, day-to-day basis, for each resident for whom the facility is holding personal incidental funds. Each receipt or disbursement of funds must be posted to the resident's account. Posting from supporting documentation shall be done within seven days after the transaction date.

(B) The resident account record shall show in detail with supporting documentation all monies received on behalf of the resident and the disposition of all funds so received. Persons shopping for residents shall provide a list showing description and price of items purchased, along with payment receipts for these items.

(C) Personal incidental fund individual resident accounts shall be reconciled and listed by the facility at the end of each calendar month.

(D) Personal incidental fund petty cash accounts shall be reconciled within ten days of receipt of the bank statement.

(E) The facility shall maintain a monthly list which separately lists the petty cash and savings account balances for each resident for whom the facility is managing personal incidental funds.

(F) Records and supporting documentation shall be retained for at least three years following the death or discharge of the resident.

(b) Accumulations of $50 or More

(A) The facility must, within 15 days of receipt of the money, deposit in an individual interest-bearing account any funds held in excess of $50 for an individual resident, unless this money is being managed in a Trust and Agency Account by the Senior and Disabled Services Division.

(B) The account shall be individual to the resident, shall be in a form that clearly indicates that the facility does not have an ownership interest in the funds, and must be insured under Federal or State law.

(c) Accumulations of Under $50

(A) The facility may accumulate no more than $50 of a resident's funds in a pooled bank account or petty cash fund which must be separate from facility funds.

(B) The interest earned on any pooled interest-bearing account containing residents' petty cash must be either prorated to each client on an actual interest-earned basis, or prorated to each client on the basis of his or her end-of-quarter balance.

(d) Within five business days following a resident's death, the facility shall send a written accounting of the resident's personal incidental funds to the executor or administrator of the resident's estate. If a deceased resident has no executor or administrator, the facility must provide the accounting to:

(A) The resident's next of kin; and

(B) The resident's representative; and

(C) The clerk of probate court of the county in which the resident died; and

(D) Estate Administration Unit, Senior and Disabled Services Division, 313 Public Service Building, Salem, Oregon 97310.

(e) Within five business days following a resident's death, the facility shall:

(A) Send a written accounting of the resident's personal incidental funds and a listing of resident personal property, including wheelchairs, television sets, walkers, jewelry, etc., to the Estate Administration Unit, SDSD.

(B) Hold personal property for 90 days, unless otherwise instructed by the Estate Administration Unit, SDSD.

(C) Comply with the laws of Oregon regarding disbursal of client personal incidental funds, and any advance payments, and/or call the Estate Administration Unit, SDSD, Salem, for more detailed instructions.

(7) ACCESS TO FUNDS, RECORDS.

(a) The facility must provide each resident and/or delegate reasonable access to his or her own financial records and funds.

(b) The facility must provide a written statement, at least quarterly, to each resident, delegate, or a person chosen by the resident to receive the statement. The quarterly statement must reflect separately all of the resident's funds which the facility has deposited in an interest-bearing account plus the resident funds held by the facility in a petty cash account or other account. The statement must include at least the following:

(A) Identification number and location of any account in which that resident's personal funds have been deposited;

(B) Balances at the beginning of the statement period;
(C) Total deposits with source and withdrawals with identification;

(D) Interest earned, if any;

(E) Ending balances; and

(F) Reconciliation.

(c) The facility shall provide a copy of the quarterly accounting to the local SDSD unit/Type B AAA within 15 days following the end of the calendar quarter on Form SDS 713, with a copy to the resident or an individual delegated by the resident to receive the copy.

(d) The resident or delegate must have access to funds in accordance with OAR 411-085-0350.

(e) The facility must, within ten business days of the resident's transfer or discharge, or appointment of a new delegate as documented on Form SDS 542, return to the resident or the delegate all of the resident's personal funds that the facility has received for holding, safeguarding, and accounting, and that are maintained in a petty cash fund or individual account, as well as a final accounting.

(8) CHANGE OF OWNERSHIP.

(a) The facility must give each resident or delegate a written accounting of any personal funds held by the facility before any transfer of facility ownership occurs, with a copy to the local SDSD/Type B AAA.

(b) The facility must provide the new owner and the local SDSD unit/Type B AAA with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

(9) LOCAL SDSD/TYPE B AAA RESPONSIBILITY

(a) Monitor receipt of SDS 713 forms and review them quarterly for appropriateness of expenditures.

(b) Monitor client resources for resources over the current Medicaid limit.

(c) For residents incapable of managing own PIFs and having no one to delegate to do so, attempt to determine resident wishes, seek physician input on the physician statement, and find a delegate, delegating the facility if necessary and not in conflict with resident wishes.

(d) Notify the facility of inappropriate expenditures and report uncorrected problems to SDSD Central Office, Program Assistance Section, and assist residents in obtaining legal counsel.

(e) Track expensive or reusable items purchased for clients through personal incidental funds or by the Division and assure their appropriate use after resident death.

411-070-0100 <u>Audit of Personal Incidental Funds</u>

(1) RECORDS AVAILABLE TO DIVISION. All account records and expenditure receipts for the resident's personal incidental funds shall be available in the facility for audit and inspection by representatives of the Department of Human Resources.

(2) DIVISION AUDITS. Audits of a provider's cost reports, financial records and other pertinent documents may be made by the Division to verify that the provider is complying with Federal regulations and State Administrative Rules regarding protection of residents' funds. Copies of the provider's records may be removed from the facility.

(3) DISCREPANCIES. Any discrepancies in the utilization of personal incidental funds brought to the attention of the case manager will be discussed with the facility. If the discrepancy cannot be resolved, the Division shall assist the resident in finding an attorney to represent them and/or bring the situation to the attention of the local district attorney.

(4) ABUSE OF FUNDS. Abuse of resident's personal incidental funds and/or failure to comply with SDSD personal incidental funds policy will be considered by the Division in deciding if a provider's agreement will be continued or renewed.

411-070-0105 Resident Property Records

(1) CURRENT RECORDS. The facility must maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the facility.

(2) AVAILABILITY. The property record must be available to the resident and the resident's representative.

(3) PERSONAL PROPERTY. The resident's private property must be clearly marked with his or her name.

(4) DIVISION AUDIT. These records are subject to the same audit criteria as all personal incidental funds in OAR 411-070-0100.

(5) REMOVAL FROM FACILITY. The Division may remove copies of these records from the facility.

411-070-0110 Temporary Absence From Facility (Bedhold)

(1) PAYMENT BY DIVISION. The Division does not pay for holding a client's bed when the client is absent from the facility.

(2) PRIVATE PAYMENT FOR BEDHOLD. Personal incidental funds or payment from a resident's family may be used to hold a facility bed if there are no vacancies in the facility to which other residents of the same sex could be admitted and if there is no duplicate payment from the Division. Personal incidental funds may only be used if the resident so chooses.

411-070-0115 Transfer of Residents

(1) PRIOR APPROVAL REQUIRED. A resident shall not be transferred to another facility without prior approval by the resident, the attending physician, branch worker, and the facility's director of nursing services. Reassignment of rooms within the facility requires prior notice to the case manager. All transfers, both inter and intra-facility, shall be conducted in accordance with resident's rights as described in OAR Chapter 85 of Division 411 and the transfer rules in OAR Division 88 of Chapter 411.

(2) EMERGENCY TRANSFER. In an emergency, consultation with the branch worker is waived. However, the branch worker must be notified by the facility of the resident's transfer at the earliest possible opportunity.

(3) NONCOMPLIANCE. Failure on the part of the facility administration to comply with this rule can constitute a basis for withholding payment for care of the resident involved.

411-070-0120 Discharge of Residents

When the attending physician indicates that the resident does not, or in the future will not, require long-term care, facility authorities must report this fact to the branch office no later than the first branch office working day following the physician's notification. Upon request, the branch office will assist the resident, facility, relatives, or guardian in developing plans and arrangements for discharge placement. Resident's refusal to be discharged will relieve the Division of responsibility for payment.

411-070-0125 Medicare (Title XVIII)

The Division will pay on behalf of eligible clients the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day through the 100th day of care in a Medicare certified nursing facility. The Division will pay the appropriate rate as defined in OAR 411, Division 70, for care beyond the 100th day. Payment will be subject to documentation required for the rate.

411-070-0130 Medicaid Payment for Medical Add-On Payments in Hospitals

(1) SWING BED ELIGIBILITY. To be eligible to receive a medical add-on payment under this rule, a hospital shall:

(a) Have approval from HCFA to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with Senior and Disabled Services Division to receive Medicaid payment for swing-bed services.

(2) NUMBER OF BEDS. A hospital receiving the medical add-on payment for Medicaid services under this rule may not receive Medicaid payment for more than a total of five residents at one time. The residents must require and receive services that meet the medical add-on requirements.

(3) PAYMENT.

(a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities during the current six month period;

(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the

facility rate as established in Section (3) of this rule.

(4) SERVICES PROVIDED. The daily Medicaid rate will be for the services outlined in OAR 411-070-0085 (All-Inclusive Rate).

(5) COMPLIANCE WITH MEDICAID REQUIREMENTS. Hospitals receiving Medicaid payment for swing-bed services shall comply with federal and Division rules and statutes which affect long-term care facilities as outlined in the facility's provider agreement with the Division.

(6) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager shall determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" shall mean a bed in a nursing facility which is available to the client at the time the placement decision is made.

411-070-0140 <u>Hospice Services</u>

(1) CONTRACT. The Division may enter into a contract (provider agreement) to reimburse Medicare certified hospice providers in Oregon for services provided in Medicaid certified nursing facilities under the following conditions:

(a) The Medicare-certified hospice provider shall have a written contract with the nursing facility;

(b) A copy of the completed contract shall be submitted to the Division; and

(c) The hospice provider must have a completed, written contract (provider agreement) with the Division for nursing facility-based hospice services prior to being determined eligible for reimbursement.

(2) REIMBURSEMENT.

(a) The Division shall pay the hospice provider a rate equal to 95% of the

rate which the nursing facility would otherwise receive;

(b) The hospice provider is solely responsible for reimbursing the nursing facility; and

(c) Reimbursement for services provided under this rule is available only if the recipient of such services is Medicaid-eligible, Medicare hospice eligible, and been found to need nursing facility care through the Pre-Admission Screening process.

411-070-0300 Filing of Financial Statement

(1) The provider shall file annually with the Senior and Disabled Services Division, Financial Audit Unit, the Nursing Facility Financial Statement covering actual costs based on the facility's fiscal reporting period for the period ending June 30. A Nursing Facility Financial Statement will be filed for other than a year only when necessitated by termination of a provider agreement with the Division, or by a change in ownership, or when directed by the Division. Financial reports of less than three months will not be used as the basis for biennial rate setting. Financial reports containing up to 15 months of financial data will be accepted for the reasons above or with permission of the Division prior to filing.

(2) (a) The Nursing Facility Financial Statement is due within three months of the end of the fiscal reporting period, change of ownership, or withdrawal from the program. The report must be postmarked on or before the due date to be considered timely.

(b) A one month extension may be obtained if a written request for an extension is postmarked prior to the expiration of the original three months. The Division will respond in writing to these requests.

(c) When a Nursing Facility Financial Statement is not postmarked within three months, or within four months if an extension under subsection (2)(b) of this rule was obtained, a penalty will be assessed and collected. The amount of the penalty shall be $5

per licensed nursing facility bed per day for each State of Oregon business day the Nursing Facility Financial Statement is late. The total penalty shall not exceed $50,000 per fiscal reporting period.

(A) For purposes of this paragraph, the number of licensed nursing facility beds will be the number licensed on the last day of the fiscal reporting period for which the facility failed to submit its report.

(B) Example: A 49-bed facility has a fiscal year end of 6/30 and does not request an extension. Its Nursing Facility Financial Statement is therefore due 9/30. It is postmarked 10/3. Hence, the facility is assessed a penalty of $735 ($5 x 49 x 3).

(d) The Division may assess interim penalties and deduct the amount of the interim penalties from the next Medicaid payment payable to the facility. Each interim penalty shall be the amount of the penalty that has accrued under subsection (2)(c) of this rule to the date of assessment, and which has not already been assessed as an interim penalty.

(e) A facility may request an informal conference or contested case hearing pursuant to ORS 183.413 through 183.470 within 30 days of receiving a letter from the Division informing it of assessment of an interim penalty or a penalty under this rule. OAR 411-070-0435 applies to such requests and sets forth the procedures to be followed. If no request for an informal conference or contested case hearing is made within 30 days of receiving such a letter, the interim penalty or penalty becomes final in all respects, including liability for payment of and the amount of the interim penalty or penalty.

(3) Improperly completed or incomplete Nursing Facility Financial Statements will be returned to the facility for proper completion.

(4) (a) Form SDS 35 is a uniform cost report to be used by all nursing

facility providers, except those that are hospital based.

(b) Form SDS 35A is a uniform cost report to be used by all nursing facility providers that are hospital based.

(c) Forms SDS 35 and SDS 35A shall be completed in accordance with the Division's Medicaid Nursing Facility Services Provider Guide and Audit Manual.

(5) If a provider knowingly or with reason to know files a report containing false information, such action constitutes cause for termination of its agreement with the Division. Providers filing false reports may be referred for prosecution under applicable statutes.

(6) Each required Nursing Facility Financial Statement shall be signed by a company or corporate officer or a person designated by the corporate officers to sign. If the Nursing Facility Financial Statement is prepared by someone other than an employee of the provider, the individual preparing the Nursing Facility Financial Statement will also sign and indicate his or her status with the provider.

(7) Facilities with fewer than 1000 Medicaid resident days during a twelve-month reporting period or fewer than 2.74 Medicaid resident days per calendar day, for facilities with reporting periods of less than a year, are not required to submit an SDS 35 or SDS 35A, but must submit a letter to the Senior and Disabled Services Division's Financial Audit Unit indicating they will not be submitting a financial statement. This letter is due the same day the financial statement would have been due.

(8) A Nursing Facility Financial Statement will be filed by each facility for the fiscal reporting period that ends June 30, 1997. The Nursing Facility Financial Statement filed for the period that ends June 30, 1997, will cover actual costs during the period between the facility's most recent Financial Statement filing prior to June 30, 1997 and June 30, 1997.

411-070-0302 <u>Filing of Revised Financial Statements</u>

(1) Revised Nursing Facility Financial Statements shall only be filed with prior written authorization of the Division.
(2) An amended report must be postmarked within six months of the end of the fiscal reporting period.

411-070-0305 Accounting and Record Keeping

(1) Nursing Facility Financial Statements are to be prepared in conformance with generally accepted accounting principles and the provisions of these rules. The Division has the option to prescribe and interpret these rules in conformance with generally accepted accounting principles.

(2) Financial Statements shall be filed using the accrual method of accounting except governmental facilities using the cash method of accounting may file reports using the cash method.

(3) The provider shall maintain, for a period of not less than three years following the date of submission of the Nursing Facility Financial Statement, financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved audit questions at the end of this three-year period, the records must be maintained until the questions are resolved. The records shall be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules.

(4) Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they will be disallowed.

(5) The Division will maintain each required Nursing Facility Financial Statement submitted by a provider for three years following the date of submission of the report. In the event there are unresolved audit questions at the end of this three-year period, the statement will be maintained until such questions are resolved.

(6) The records of the provider shall be available for review by authorized personnel of the Division and of the United States Department of Health and Human Services during normal business hours at a location in the State of Oregon specified by the provider.

(7) Accrued expenses that are forgiven by a creditor will be considered as income to the facility and offset against expenses in the subsequent period. Accruals that are settled at less than full value will have the forgiven amount considered as income and offset against expenses.

411-070-0310 Auditing

(1) All Nursing Facility Financial Statements are subject to desk review and analysis within six months after proper completion and filing.

(2) The desk review will determine, to the extent possible:

(a) That the provider has properly included its costs on the Nursing Facility Financial Statement in accordance with generally accepted accounting principles and the provisions of these rules; and

(b) That the provider has properly applied the cost finding method specified by the Division to its allowable costs determined in Subsection (2)(a) of this rule; and

(c) Whether further auditing of the provider's financial and statistical records is needed.

(3) All filed Nursing Facility Financial Statements are subject to a field audit, normally to be completed within one year from the date of filing.

(4) The field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to; and

(b) Reported data are in agreement with supporting records; and

(c) The Nursing Facility Financial Statement is reconcilable to the appropriate IRS report and payroll tax reports.

411-070-0315 Maximum Allowable Compensation of Administrator and Assistant Administrator

(1) The maximum compensation of a full-time (40 hours per week) licensed administrator to a nursing facility shall be allowable at the lower of compensation actually received or the amount determined during the biennial rate-setting process.

(2) The maximum compensation of not more than one full-time (40 hours per week) assistant administrator to a nursing facility with at least 80 licensed beds shall be allowable at the lower of compensation actually received or seventy-five percent of the allowable administrator compensation for the number of licensed beds in the nursing facility. The Division will not allow the cost of an assistant administrator in a facility with less than 80 beds.

(3) If either of the above individuals works less than 40 hours in the average week, allowable compensation shall be the lower of actual compensation received or the amounts determined during the biennial rate setting process, multiplied by the percentage of 40 hours worked in the average week. The provider shall maintain adequate records to demonstrate time actually spent.

(4) The maximum allowable administrator compensation shall be adjusted each year and will be effective as of January 1 each year. The rates shall be established using the gross allowable compensation in Account 411 (Administrator Compensation) of the Nursing Facility Financial Statement for non-owner administrators. The applicable compensation amounts will be inflated by the U.S. CPI from the mid point of each facility's fiscal year to July 1. The 75th percentile of each bed-size category, 1-49, 50-79, 80-99, 100 and over, will be the ceiling for each grouping.

(5) When a single individual serves as the administrator of both a nursing

facility and a hospital, the salary will be pro-rated to both functions. The nursing facility portion will then be compared to the pro-rated share of the allowable administrator compensation to determine the amount to be included as allowable. (For example, if the administrator works 50% of the time in the nursing facility, one-half of his salary will be allocated to the nursing facility. This amount will be compared to one-half of the allowable administrator's compensation to determine the allowable compensation in the nursing facility.)

411-070-0320 Consultants

(1) Costs for direct care and dietitian consultant services to the staff of the facility will be allowed.

(2) No other consultant costs will be allowed.

(3) Payment for treatment and evaluation provided directly to an individual resident by medical providers will not be paid by Senior and Disabled Services Division.

411-070-0330 Owner Compensation

(1) Reasonable compensation for services performed by owners (whether sole proprietors, partners, or stockholders) is an allowable cost, provided the services are actually performed, documented, and are necessary, and the provisions of this rule are met.

(2) The allowance of compensation for services of sole proprietors and partners is the amount determined by the Division to be the reasonable value of the services rendered as long as compensation was paid in conformance with this rule.

(3) Compensation for services performed by owners may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and rendered in connection with resident care. Services rendered in connection with resident care include both direct and indirect activities in the provision

and supervision of resident care, such as administration, management, and overall supervision of the institution. Services which are not related to either direct or indirect resident care; e.g., those primarily for the purpose of managing or improving the owner's financial investment are not recognized as an allowable cost. Costs related to the owner's management and overall supervision of the facility will be reported in Account 436.

(4) Payments to an owner which represent a return on equity capital are not allowable costs for reimbursement purposes. Such payments are not considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

(5) The compensation allowance shall be an amount as would ordinarily be paid for comparable services in other nursing facilities, as defined by Section (6) of this rule. This determination will be made by the Division depending upon the facts and circumstances of each case.

(6) For purposes of determining whether the compensation paid to or claimed by an owner is reasonable, the total of all benefits and remuneration such as travel allowance or key-man insurance, regardless of the form, will be considered. The Division has established the 75th percentile ranking of average compensation paid, in all facilities by job category, as being reasonable.

(7) Accrued compensation of an owner, if not paid within seventy-five days after the end of the Nursing Facility Financial Statement reporting period, shall not be included as an allowable expense.

(8) An owner shall not be compensated for services in excess of forty hours in one week. This rule applies even if an owner may provide services in more than one area.

(9) The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

(10) Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives"; husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild, uncle, aunt, nephew, niece, and cousin.

(11) The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the manner in which this authority and responsibility is actually exercised.

(12) Where an owner provides services for more than one facility or is engaged in other occupations or business activities, allowable compensation shall be adjusted to reflect an appropriate allocation of time spent in each area based on the combined total of resident days.

(13) Where an owner functions as an administrator or assistant administrator, the rules governing compensation of these positions apply, in addition to the requirements of this rule.

411-070-0335 <u>Related Party Transactions</u>

(1) Costs applicable to services and supplies furnished to a provider by organizations related to the provider by common ownership or control are allowable at the lower of cost excluding profits and markups to the related party or charge to the facility. Such costs are allowable to the extent that they relate to resident care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. Documentation of costs to related parties (including those identified in Rule 411-070-0330(10)) shall be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(2) An exception is provided to the general rule in Section (1) of this rule applicable to related organizations. The exception applies if the

provider demonstrates by convincing evidence to the satisfaction of the Division:

(a) That the supplying organization is a separate legal entity; and

(b) That 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. Prices paid by the provider shall not be in excess of what would be paid by a prudent cost conscious buyer.

(3) If the provider takes the position that an exception as stated in Section (2) of this rule applies, then the provider shall:

(a) Make available the books and records of the related organization to SDSD auditors; and

(b) Maintain a receiving report signed by personnel of the nursing facility for services or supplies furnished by the related organization.

(4) Rental expense paid to related organizations for facilities shall be allowable to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of these rules. The exception listed in Section (2) of this rule does not apply to rental expense paid for facilities.

411-070-0340 Chain Operations

(1) A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations.

(2) Although the home office of a chain is normally not a provider in itself, it may furnish to the individual provider central administration and/or other services such as centralized accounting, purchasing, personnel or management services. Only the home office's actual cost of providing such services is includable in the provider's allowable costs under the program.

(3) Home office costs that are not otherwise allowable costs when incurred directly by the provider are not allowable as home office costs to be allocated to providers. Where the home office is a mere holding company and provides no services related to resident care, no costs of the home office are allowable to the providers in the chain or single facility.

(4) Where an owner receives compensation from the home office for services to the facility, the compensation is allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined under owner's compensation.

411-070-0345 <u>Allocation of Home Office and Regional Office Costs</u>

(1) The initial step in the allocation of home office and regional office costs is direct allocation of all allowable costs directly attributable to a particular nursing facility (such as construction interest, salary where the administrator of a nursing facility in the chain is paid directly by the home office, etc.) or non-nursing facility activity.

(2) Other allowable costs shall appropriately be allocated among the providers (and to any non-provider activities in which the home office or regional office may be engaged) on the basis of beds, resident days, or other bases, whichever most equitably allocates such costs. Revenues are not generally appropriate for distributing these costs. Where possible, allocation of costs are to be based on function and, consequently, the bases of allocation may appropriately be different, say for accounting costs and for personnel costs. Where the home office or regional office incurs costs for activities not related to resident care in the chain's participating providers, the allocation basis must provide for all allocation of costs such as rent, administrative salaries,

other general overhead costs, organization costs, etc., which are attributable to non-resident care as well as resident care activities.

(3) The third step is to enter the allocated costs in the Home Office column for each account identified.

411-070-0350 Management Fees

Management fees are an allowable expense if they are necessary, reasonable, non-duplicative of facility personnel and functions, and documented by a binding contract with a non-related party defining the items, services, and activities provided. If the administrator or assistant administrator are supplied as part of the contract, the rules governing their compensation in these rules apply. Documentation demonstrating that the services were actually performed is required. Management fees paid to a related organization are subject to the rules governing related parties (Rule 411-070-0335), chain operations (Rule 411-070-0340), and allocation of home office costs (Rule 411-070-0345). The allowable salary paid to the administrator and assistant administrator are included in the total facility management fee calculation. Total management fees for allowable management and supervisory services shall not exceed the limits established for the administrator and the assistant administrator in Rule 411-070-0315 plus $5,000 allowable for other management fees per year.

411-070-0359 Allowable Costs

(1) Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident care.

(a) Interest - Interest on debt related to the provision of resident care services is an allowable expense, except on or after July 1, 1984, interest expense related to that portion of the acquisition price of a long-term care facility that exceeds the depreciable basis (Rule 411-070-375) will not be reimbursable. That portion of interest expense related to property or equipment shall be reported in accordance with Rule 411-070-359(1)(bb).

(b) Rent or Lease Payments - Payments for the lease or rental of land, buildings, and equipment are to be reported. Payments for lease agreements entered into with a related party are limited to the lower of actual costs or the lease payments. These costs shall be reported in accordance with Rule 411-070-0359(1)(bb).

(c) Depreciation and Amortization - Depreciation schedules on buildings and equipment must be maintained. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. These costs shall be reported in accordance with Rules 411-070-0359(1)(bb), 411-070-0365, 411-070-0375 and 411-070-0385.

(d) Salaries (Except Owners and Related Parties) - Salaries and wages of all employees engaged in resident care activities or overall operation and maintenance of the facility, including support activities of home offices and regional offices, shall be allowable.

(e) Compensation of Owners - Owner's compensation in accordance with Rule 411-070-0330 is allowable.

(f) Payroll Taxes - The employer's portion of payroll taxes is reimbursable.

(g) Employee Benefits - Employee benefits that are made available to all employees, are for the primary use of the employees, are generally considered by the industry as reasonable and important benefits to provide employees, are not taxable as wages, and are allowable to the extent of employer participation.

(h) Supplies - Cost of supplies used in resident care or providing services related to resident care are allowable.

(i) Auto and Travel Expense - Expense of maintenance and operation of a vehicle and travel expense related to resident

care are reimbursable. The allowance for mileage reimbursement will not exceed the amount determined reasonable by the Internal Revenue Service for the period reported. Allowable out-of-state travel is restricted to Washington, Idaho and Northern California no farther south than San Francisco. One out of the state/ contiguous area trip per year for two employees shall be allowed, as long as it relates to resident care.

(j) Bad Debts - Bad debts related to Title XIX recipients are allowable.

(k) Bank and Finance Charges - Charges for routine maintenance of accounts are allowable.

(l) Purchased Services - Services which are received under contract arrangements are reimbursable to the extent that they are related to resident care and the sound conduct and operation of the facility.

(m) Taxes - Property taxes on assets used in rendering resident care are allowable.

(n) Insurance - Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to resident care. Self-insurance costs are allowable only when expense is actually incurred.

(o) Repairs and Maintenance - Costs of maintenance and minor repairs are allowable when related to the provision of resident care.

(p) Education & Training - Registration, tuition and book expense associated with education and training of personnel is allowed provided it is related to resident care. The costs associated with training and certifying nurse aides are not allowable for inclusion in the annual Nursing Facility Financial Statement. These costs are reimbursed separately by the Division, per OAR

411-070-0470.

(q) Advertising - Help wanted advertising and the expense related to the alphabetical listing in the yellow pages of a phone directory are allowable.

(r) Accounting, Auditing, and Data Processing - The costs of recording, summarizing, and reporting the results of operations are allowable.

(s) Licenses, Dues, and Subscriptions - Fees for facility licenses, dues in professional associations, and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff professional use are allowable.

(t) Legal Fees - Legal fees directly related to resident care are allowable. Legal fees related to non-allowable costs are not allowable. (For example, legal fees to collect non-Medicaid bad debts would not be allowable.) Legal fees claimed as related to resident care shall be explained and listed on Schedule A. Fees related to legal and administrative actions to resolve a disagreement with the state will be allowable if the action is resolved in the provider's favor, and the judge/hearings officer does not order the State to pay the provider's legal fees.

(u) Management Fees - Management fees are allowable provided they meet the criteria for Rule 411-070-0350, Management Fees.

(v) Postage and Freight - Postage expense is considered an office supply cost. Freight will be posted to the same account as the item purchased.

(w) Food - Food products and supplements used in food preparation are allowable.

(x) Utilities - Costs for facility heating, lighting, water-sewer, and garbage provision are allowable.

(y) Linen and Bedding - Linen and bedding costs for the facility are allowable.

(z) Consultant Fees - Consultant fees are allowable provided they meet the criteria for Rule 411-070-0320, Consultants.

(aa) Utilization Review - Costs incurred for utilization review are Medicare related and are not allowable for Medicaid reimbursement.

(bb) Property Costs - Costs related to purchase or lease of a facility are to be reported in Accounts 452 through 459 and 461.

(cc) Communications - Charges for routine telephone service, including pagers, and cable television fees, are allowable.

(dd) Home Offices Costs - Home office costs are allowable in accordance with Rule 411-070-0345.

(ee) Allowable Workers Compensation Dividends (Refunds) or Billings of the nursing facility are those dated in the fiscal reporting period.

(ff) Criminal Records Checks - Costs of criminal record checks of facility employees if mandated by federal or state law.

(2) Exceptions to the items listed in Section (1) of this rule must be approved in writing to be allowable. Exceptions shall not be granted for the following items:

(a) Amortization of non-competitive agreement;

(b) Good will;

(c) Federal and other governmental income taxes;

(d) Penalties and fines;

(e) Costs of services and items otherwise reimbursable through the Office of Medical Assistance Programs, other third party payors (see Rule 411-070-0359(3)), or the resident's personal funds.

(f) The cost related to the functioning of Corporate Boards of Directors.

(g) Advertising for purposes of soliciting potential residents, except for listings in the yellow pages (see Rule 411-070-0359(1)(q)).

(h) The cost of salaries and supplies devoted to religious activities.

(i) Gifts and contributions.

(3) Third Party Payors. The purpose of this section is to assure that facilities are not paid twice, once through the Medicaid all-inclusive rate and again through a third party payor, for providing a service. This section includes both allowed and non-allowed costs.

(a) Facilities must bill third party payors for nursing facility services whenever payment from a third party payor is or may be available. Examples of such payors are Medicare, Veterans Administration, insurance companies or a private resident when the items are not included in the basic rate.

(b) The Division shall provide and update a summary listing of those items that may be billed to Medicare Part B for eligible residents. The costs for these items are not allowable for inclusion in the Nursing Facility Financial Statement for the purpose of establishing total facility per day costs.

(c) For Medicaid residents who are not Medicare Part B eligible, the costs of the items on the list provided by the Division per Section (3)(b) of this rule will be used to establish an add-on to the costs per resident day not to exceed the maximum direct care ceiling. These costs will be divided by the basic rate and the pediatric rate total Medicaid days and the resultant amount will be added to the facility's per resident day direct care cost.

(d) Revenues received from third party payors, on behalf of Medicaid residents, for items other than those on the Medicare Part B list must be reported on the Nursing Facility Financial Statement. These revenues will be divided by the basic rate and the pediatric rate total Medicaid days and the resultant amount will be used to reduce the facility's per resident day direct care costs.

(e) Facilities must submit as an attachment to their Nursing Facility Financial Statement a list showing name, case number, and total dollars expended or other allocation methodology approved in advance by the Division for the listed Medicare Part B eligible items per client for Medicaid residents not eligible for Medicare or other third party payments. Facilities may elect to use an allocation method to determine the dollars expended as long as the Division approves of the method thirty days in advance of the facility's fiscal year end. The Division shall approve or reject the allocation method in writing within 30 days from the receipt of the facility's request for approval. The Division's approval of the allocation method continues from year to year unless notified in writing by the Division. Once an allocation method is approved, other facilities may use this method by notifying the Division of their intent to adopt this method thirty days in advance of the facility's fiscal year end. This attachment will be required for all reporting periods with an ending date after December 31, 1992.

(f) Failure to bill or collect from third party payors whenever appropriate will not cause these expenses to be considered allowable.

(g) Therapies provided by facility employees are allowable or not allowable as indicated below:

(A) Therapy expenses for non-Medicare eligible Medicaid residents may be included in the calculation in Subsection (3)(c) of this rule.

(B) The facility must establish a methodology which clearly indicates the approach taken to identify these allowable costs. This allocation method must be approved by the Division as described in Subsection (3)(e) of this rule.

(C) The portion of the therapist(s) costs which will be allowed in computing the base direct care rate includes:

(i) Therapies provided to Medicare Part B eligible residents which are not reimbursed by Medicare because the person's condition is no longer improving; and
(ii) Other services performed but not required by physician orders.

(D) The following categories of therapy services are not allowable except as otherwise allowed under Section (3) of this rule:

(i) Medicare Part A or Part B reimbursed services for Medicaid and other clients;

(ii) Privately reimbursed services, including insurance;

(iii) Services reimbursed by the Veterans Administration;

(iv) Services to non-Medicare eligible Medicaid residents except to the extent otherwise allowed under Section (3) of this rule; and

(v) Services reimbursed by any third party.

(h) The cost of services incurred for therapy services performed by non-employee therapists are reimbursable through a third party payor or the Office of Medical Assistance Programs (OAR 411-070-0355) and are non-allowable on the Nursing Facility Financial Statement.

(i) The cost of supplies and equipment medically necessary in the performance of therapy services, which are reimbursable through a third party payor or the Office of Medical Assistance Programs (OAR 411-070-0355), are non-allowable on the Nursing Facility Financial Statement.

411-070-0365 Capital Assets

(1) The following costs shall be capitalized and depreciated: Expenses for depreciable assets with historical cost in excess of $1,000 per unit, or in aggregate, and a useful life greater than one year from the date of purchase.

(2) Repair costs in excess of $1,000 on equipment or buildings must be capitalized.

(3) The provider shall maintain schedules of capital assets and depreciation, on a straight line basis, to document amounts on the Nursing Facility Financial Statement.

411-070-0370 Depreciable Assets

(1) Tangible assets of the following types in which a provider has an economic interest through ownership are subject to depreciation:

(a) Buildings - The basic structure or shell and additions thereto.
(b) Building fixed equipment - Attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. The general characteristics of this equipment are:

(A) Affixed to the building and not subject to transfer;

(B) A fairly long life but shorter than the life of the building to which affixed.

(c) Movable equipment - Such items as beds, wheelchairs, desks,

vehicles, and other depreciable items. The general characteristics of these equipment are:

(A) Capable of being moved.

(B) Subject to control and meeting the definition of a capital asset.

(d) Land improvements - Such items as paving, tunnels, underpasses, onsite sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the provider.

(e) Leasehold improvements - Betterments and additions made by the lessee to the leased property which become the property of the lessor after the expiration of the lease.

(2) Land is not depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, and the cost of curbs and sidewalks, replacement of which is not the responsibility of the provider.

411-070-0375 <u>Depreciation Basis</u>

(1) Purchase of a Nursing Home

(a) New facility - The depreciation basis of a new facility shall be the historical cost of building the facility, including preparation for use, or the purchase price from an unrelated organization not to exceed the fair market value, including preparation for use, less salvage value.

(b) Ongoing facility - The depreciation basis of the purchase of an ongoing facility from an unrelated organization is limited to the lower of the following:

(A) The allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984; or

(B) The acquisition cost of such asset to the new owner.

(c) To properly provide for costs or valuations of fixed assets, an appraisal by an appraisal expert will be required if the provider has no historical cost records, or has incomplete records of depreciable fixed assets, or purchases a facility without designation of purchase price for the classification of assets acquired. The appraisal is subject to the approval of the Division. In any case, the Division may require such an appraisal to establish the fair market value of the provider assets.

(d) If the purchase is from a related organization, the cost basis is the lower of the cost basis of the related organization or the cost basis as determined in (b) and (c) above, less depreciation as determined by the provisions of these rules.

(2) The depreciation basis of other assets shall be the historical cost to the provider from an unrelated organization plus set-up costs, less salvage value. In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid. In a case where the asset is purchased from a related organization, the depreciation basis shall not exceed the assets' book value to the related organization as determined under the provisions of this guide.

(3) The depreciation basis of donated assets, defined as an asset acquired without making any payment for it in the form of cash, property, or services, shall be the lesser of;

(a) Fair market value at the date of donation adequately documented in the provider's records or by appraisal by an appraisal expert, less savage value; or

(b) If from a related organization, the depreciation basis shall be the lessor of:

(A) Fair market value; or

(B) The depreciation basis the related party had or would have had for the asset under the program.

411-070-0385 Depreciation Lives

(1) The provider shall use the "Estimated Useful Lives of Depreciable Hospital Assets" guidelines for asset lives when computing depreciation.

(2) For assets not covered by the guidelines and with costs of more than $1,000 per unit, or in aggregate, the lives established by the provider are subject to approval by the Division.

(3) Depreciation and amortization schedules must be maintained.

(4) Depreciation expense is not allowed on land.

(5) Depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset.

411-070-0400 Equity

Equity is not an allowable expense for reimbursement but must be reported. Equity capital is the net worth of the provider (owner's equity in the net assets as determined under these rules), adjusted for those assets and liabilities which are not related to the provision of resident care.

(1) Generally accepted accounting principles are to be used unless otherwise specified in these rules for computing owner's equity.

(2) Assets and liabilities not related to providing resident care are not includable in the provider's equity capital.

(3) Loans from owners or related entities are considered as invested equity capital of the provider.

(4) Owner's equity in assets leased from related entities is includable in the equity capital of a proprietary provider.

(5) Goodwill is not includable as part of owner's equity.

(6) Invested funds that are diverted to income producing activities which are not resident related for more than six months will not be included as part of owner's equity.

(7) Amounts deposited in a funded depreciation account and the earnings on deposits are not included in equity capital. Interest earned on these funds is not offset against interest expense.

(8) Land, buildings and other assets acquired in anticipation of expansion are not includable in equity capital. Construction-in-process and liabilities related to such construction are not includable in equity capital.

(9) Prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as the beneficiary, are not included when computing equity capital.

(10) The costs of noncompetitive agreements are not includable in equity capital.

(11) The amount deposited and the earnings on self-insurance reserve funds are not includable in equity capital.

(12) When an asset is totally or partially destroyed by a casualty, the unrecovered loss is not included in equity capital.

(13) Working capital, defined as the difference between current assets and current liabilities, shall be adjusted by any amount considered to be excessive for the necessary and proper operation of resident care activities. The excessive amount will not be included in equity capital.

(14) The cash surrender value of insurance is not includable in equity capital.

(15) Imputed salaries for proprietors will be offset in computing the equity capital.

(16) Any portion of an acquisition cost, incurred on or after July 18, 1984, that exceeds the depreciable basis is not includable in the owner's equity calculation.

411-070-0415 Offset Income

(1) Income is offset against expenses unless specifically excluded in Section (2) of this rule. If an adjustment is for a revenue producing activity representing a non-allowable cost, the revenue shall be offset against the appropriate expense if the revenue is less than 2% of the total provider expense (sum of cost areas). Where the revenue is greater than 2% of the total provider expense (sum of cost areas), costs shall be allocated to this area as described in Rule 411-070-0430, Allocation Methods.

(2) Income items that shall not be offset are:

(a) Ancillary income and charges for routine services or supplies that are included in the all inclusive rate but charged to other residents (except as required in Rule 411-070-0359(3));

(b) Grants, unless designated for paying a specific operating cost;

(c) Donations, unless designated for paying a specific operating cost.

(3) (a) Revenue received for pediatric residents will be offset against expenses. These revenues will not be subject to the 2% limitation established in Section (1) of this rule.

(b) The revenue will be offset against cost centers in the same ratio as reported by the facility in accordance with Rule 411-070-0452.

(4) Mental Health revenues received from local governments to provide extra care to Medicaid residents must be reported in SDSD Account 819, directly offset against the related expense and explained on Schedule A. (For example, payments from County Mental Health Offices to finance the additional care of residents requiring the assistance of Mental Health professionals.)

411-070-0417 Treatment of Medical Add-On

(1) The medical add-on reflects the additional costs of providing skilled nursing services for certain residents due to their needs.

(2) The medical add-on is added to the basic rate.

(3) When calculating per resident day care compensation cost, the treatment of the medical add-on is as follows:

(a) The allowable care compensation costs for both the basic rate and the medical add-on are divided by total basic rate resident days.

(b) Revenue from the medical add-on received for eligible clients is divided by the number of Medicaid basic rate resident days.

(c) The per resident day amounts computed in section (3)(a) of this rule are reduced by the per Medicaid resident day amounts computed in Section (3)(b) of this rule. The result is defined as care compensation per resident day and will be used in determining the prospective base rate.

411-070-0420 Base Year Cost Finding

(1) The provider shall report its gross costs and shall make reclassifications and adjustments to costs as provided in these rules. This process will determine net allowable costs on the Nursing Facility Financial Statement which includes a uniform chart of accounts provided by the Division. The gross costs and revenues shall agree with the statement of earnings and expenses or profit and loss statement of the provider. Revenues are to be reported in the same

manner as costs on the Nursing Facility Financial Statement. The provider shall also use the balance sheet provided to report its gross assets, gross liabilities, and gross equity, make reclassifications and adjustments as provided by these rules.

(2) The per diem costs of care shall be used to determine each provider's allowable per diem costs and shall be effective for the same period as covered by the Nursing Facility Financial Statement.

(3) The per diem costs of each facility will be used to establish the basic rate on July 1 of each odd numbered year.

(4) Costs, revenues, assets, liabilities, and owner's equity attributable from a home office or regional office to a provider under Rule 411-070-0345 will be included on the Nursing Facility Financial Statement in the Home Office column. The home office financial data shall be reconcilable to the home office financial statements and records.

411-070-0425 Resident Days

The provider shall keep census records on all residents.

411-070-0428 Cost Center Expenses

(1) For purposes of establishment of payment rates under the system in effect on June 30, 1997, allowable expenses are divided into two categories for rate setting purposes. The categories are composed of the following accounts:

(a) Indirect Costs

(A) Property Costs

452 Interest
453 Rent - Building
454 Lease - Equipment
455 Depreciation - Building
456 Amortization - Land Improvement

457 Depreciation - Building Improvement
458 Depreciation - Equipment
459 Amortization - Leasehold Improvement
461 Miscellaneous Property

(B) Administrative and General

411 Administrator
412 Assistant Administrator
415 Other Administrative Salaries
443B Employee Benefits and Taxes
425 Office Supplies
426 Communications
427 Travel
429 Advertising - Help Wanted
431 Public Relations
432 Licenses - Dues - Subscriptions
433 Accounting and Related Data Proc.
435 Legal Fees
436 Management Fees
441 Bad Debts
439 Other Interest Expense
445B Education and Training
446 Contributions
447 Donated Services
448 Freight
449 Miscellaneous

(C) Other Operating Support

443D, E, F, G Employees Benefits and Taxes
451 Real and Personal Property Taxes
460 Insurance
511 Compensation - Repair and Maintenance
512 Heat and Electricity
515 Water - Sewer - Garbage
516 Maintenance Supplies and Service
521 Compensation - Dietary

527, 537, 547 Purchased Services
528 Dietary Supplies
531 Compensation - Laundry
532 Linen and Bedding
538 Laundry Supplies
541 Compensation - Housekeeping
548 Housekeeping Supplies
519, 529, 539, 549 Miscellaneous

(b) Direct Costs

(A) Food

522 Food

(B) Direct Care Compensation

443H Employee Benefits and Taxes
601 Compensation - Director of Nursing Services
611 Compensation - Registered Nurses
621 Compensation - LPNs
631 Compensation - Other Nursing
701 Compensation - Physician
711 Compensation - Pharmacy
721 Compensation - Laboratory
731 Compensation - X-Ray
741 Compensation - Activities and Recreation
751 Compensation - Rehabilitation
761 Compensation - Religious
771 Compensation - Other Services
781 Compensation - Other
787 Purchased Services

(c) Direct Care Supplies

445I Education and Training
625 Medical Record Supplies
629 Nursing Supplies

639 Oxygen Supplies
719 Physician Fees
723 Drugs and Pharmaceuticals - NH
728 Drugs and Pharmaceuticals - Presc.
729 Pharmacy Supplies
739 Laboratory Supplies and Fees
749 X-Ray Supplies and Fees
759 Activity and Recreational Supplies
769 Rehabilitation Supplies and Fees
782 Utilization Review
789 Consultant Fees
799 Miscellaneous

(2) The allocation methods, identified in Rule 411-070-0430, will be used where allocation among separate levels of payment or activities is appropriate.

411-070-0430 <u>Allocation Methods</u>

(1) The provider shall use the allocation methods designated on the Nursing Facility Financial Statement.

Cost Area	Allocation Method
Property	Resident Days or Square Footage
Administrative and General	Resident Days
Other Operating Support	Resident Days
Food	Resident Days
Direct Care Compensation	Actual Cost or Resident Days
Direct Care Supplies	Actual Cost or Resident Days

(2) Where costs are related to non-nursing facility activities, the provider shall use an appropriate allocation method to reasonably and accurately allocate these costs (see Rule 411-070-0415). For residential care facility clients, the facility will use resident days for all areas except Direct Care Compensation and Direct Care Supplies and Property. The Direct Care Compensation and Direct Care Supplies allocation will be actual costs incurred. The Property allocation method

may be based on either resident days or on square footage and must be designated on the Nursing Facility Financial Statement.

(3) Square footage will be used to allocate property costs to pediatric units as defined in Rule 411-070-0452.

(4) Actual payroll for the Pediatric Unit will be used as the basis for allocating Direct Care Compensation to pediatric units.

(5) If the Division determines that for a provider it is more reasonable and accurate to use a different allocation method than specified in Sections (1) and (2) of this Rule, then such allocation method shall be used.

411-070-0435 Appeals

(1) The Division shall send letters to a provider which inform the provider of any changes made by the Division from the provider Nursing Facility Financial Statement. A provider is entitled to an informal conference or a contested case hearing pursuant to ORS 183.413 -183.470, as described in sections (2) or (3) of this rule, to protest the change(s).

(2) The provider may request an informal conference, by notifying the Division in writing within 30 days of receipt of the letter from the Division which informs the provider of the change(s). The request for an informal conference must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the conference. At the informal conference, the provider may submit documentation and explain the basis for the provider's protest. Following the informal conference, the Division shall notify the provider of its decision by mail. No judicial review is available following a decision from an informal conference. If the provider is not satisfied with the decision, the provider may request a contested case hearing pursuant to ORS 183.413-183.470 by notifying the Division in writing of the request for the hearing within 10 working days of the date of the decision letter from the informal conference. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480-183.497.

(3) As an alternative to section (2) of this rule, the provider may request a

contested case hearing pursuant to ORS 183.413 - 183.470 by notifying the Division in writing that a contested case hearing is requested within 30 days of receipt of the letter from the Division which informs the provider of the change(s). The request for the contested case hearing must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the hearing. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480 - 183.497.

(4) If no request for an informal conference or contested case hearing is made within the specified time period, the most recent decision from the Division shall automatically become a final order.

(5) A provider may request documentation supporting the change(s) from the Division; however, a request for documentation does not toll the time period within which an informal conference or contested case must be requested. The Division shall produce these work papers within 30 days of receipt for a written request.

411-070-0440 <u>Per Diem Rate Setting</u>

For the State fiscal year commencing July 1, 1997, the prospective base rate will be established as follows:

(a) Rates will be based on the latest Nursing Facility Financial Statement received by the Division by December 31, 1996, for the fiscal reporting period ended September 30, 1996, or earlier.

(b) The Division will first compute the expected rates that would have been computed under OAR 411-070-0440(2)(d) as it existed on June 30, 1997. The Division will desk review or field audit the financial statements and then rank the total allowable per diem direct care costs from highest to lowest for each facility.

(c) Direct care costs for each facility will be calculated by

combining the allowable costs for Direct Care Compensation, Direct Care Supplies and Food.

(d) Allowable costs will be determined using the administrative rules in effect on June 30, 1997. Before ranking the allowable direct care costs, these costs will be inflated. The allowable costs of each facility will be inflated by the DRI Index. The most recent version of the DRI Index will be used. Costs will be inflated to reflect projected changes in the DRI Index from the mid-point of each facility's cost reporting period to the mid-point of the base year.

(e) Per resident day costs will be ranked, and the maximum payment levels for NF Payment Categories 2 and 4, as defined in OAR 411-070-0025 and 411-070-0027, in effect June 30, 1997, will be set at the 70th percentile.

(f) The Indirect Cost Center will be computed as a flat rate for all nursing facilities under the rules in effect as of June 30, 1997. The state-wide indirect flat rate determined as of July 1, 1997, will be inflated by the change in the USCPI between December, 1995 and December, 1996. After inflating the indirect rate, two cents per resident day will be added to comply with OAR 411-070-0459 as it existed on June 30,1997.

(g) Projected expenditures for each facility for the rate years July 1, 1997-98 and July 1, 1998-99, respectively, will be computed as follows:

(A) Compute the statewide weighted average direct care cost for NF Payment Categories 2 and 4 from the Nursing Facility Financial Statement used in subsection (1)(a) of this rule;

(B) Compute the statewide weighted average direct care costs for NF Payment Categories 2 and 4 from the Nursing Facility Financial Statements for the period preceding the period used in subsection (1)(a) of this rule;

(C) Compute the percentage increase in direct care costs for

each payment category by comparing the two periods.

(h) Using the growth rate computed in subsection (1)(g)(C) of this rule, inflate the direct care costs for NF Payment Categories 2 and 4, for each cost report used in subsection (1)(a) of this rule, to fiscal years ending in 1997, 1998 and in the first six months of 1999.

(i) Inflate the direct care ceilings computed in subsection (1)(e) of this rule to the mid-point of the facility fiscal year, using the projected change in the DRI Index for the calendar year 1997.

(j) Inflate the indirect care rate to July 1, 1998, using the projected change in the USCPI between December, 1996 and December, 1997.

(k) Compute projected rates for each facility, for each rate level, using projected costs from subsection (1)(g)(C) of this rule, direct care ceilings from subsection (1)(e) of this rule, and indirect care rates from subsection (1)(f) of this rule. NF Payment Categories 3 and 5 will be projected using NF Payment Categories 2 and 4, respectively, as computed in this rule, plus the NF Payment Categories 3 and 5 add-ons from July 1, 1996, inflated forward using the projected changes to the DRI Index. The computation of rates will be in accordance with OAR 411-070-0460, as it existed on June 30, 1997, except that no OBRA or minimum wage add-ons will be used.

(l) Compute the base pool for allocation for the 1997-99 biennium using the weighted average rates computed in subsection (1)(k) of this rule multiplied by the projected caseload for the 1997-99 biennium.

(m) The base will be allocated as follows:

(A) The pediatric nursing facility rate will be established in accordance with OAR 411-070-0452.

(i) Payments being made to facilities on behalf of pediatric clients will be based on the rates the Division is paying on behalf of clients in a pediatric nursing facility, or in a self-contained pediatric nursing unit, as of December 31, 1996. These rates will be inflated from December 31, 1996 to the midpoint of the base year using the DRI Index. The most recent DRI will be used.

(ii) The pediatric rate will be multiplied by the number of clients for whom this rate was being paid by the Division based on the latest Nursing Facility Financial Statement received by the Division as of December 31, 1996. The resulting product will be removed from the allocation base and set aside to pay the pediatric rate.

(B) The basic rate will be established as follows:

(i) After the amount necessary to fund the pediatric rate is removed from the base, as described in this rule, the remaining base shall constitute the funds available for the basic rate and for the medical add-on.

(ii) The medical add-on shall be 40% of the basic rate.

(iii) After setting aside the amount of funds necessary to pay the medical add-on, the remaining base shall be used to fund the basic rate.

(iv) Funds to be set aside for the medical add-on will be calculated based on an estimate of the number of Medicaid residents of nursing facilities who meet the medical add-on criteria in June 1997.

(v) The basic rate shall be determined by dividing the remaining base by the projected cases for the 1997-

99 biennium not eligible to receive the pediatric rate.

(2) In future rebasing years, rates for the first year of the biennium will be set as follows:

(a) Rates will be based on financial statements received by the Division by September 30 (or postmarked by October 31, if an extension of filing has been approved by the Division) which cover fiscal periods ending in the last fiscal reporting period (July 1 to June 30) of the year preceding the effective date of the new rate.

(b) To establish rates, the Division will desk review or field audit the financial statements and determine the statewide average allowable cost per Medicaid resident day. However, the costs of pediatric nursing facilities and self-contained pediatric units will be excluded from this ranking.

(c) Before determining the statewide average allowable costs per Medicaid day, these costs will be inflated by the DRI Index as measured in the previous fourth quarter. Costs will be inflated to reflect projected changes in the DRI Index from the mid-point of each facility's cost reporting period July 1 of the base year.

(d) The relationship the basic rate from the July 1, 1997 per diem rate setting bears to the statewide average cost per Medicaid day as of July 1, 1997 shall be referred to as the relationship percentage. The relationship percentage is determined to be 90.18%.

(A) The basic rate from the July 1, 1997 rate setting is $86.75 per day.

(B) The statewide average cost per Medicaid day as of July 1, 1997 is determined to be $96.20. The cost was determined as:

(i) The statewide average cost per Medicaid day

calculated in subsections (1)(e) and (1)(f) of this rule is inflated to December 31, 1996 using the facility specific growth rate computed in subsection (1)(g)(C) of this rule.

(ii) The statewide average cost per Medicaid day as of December 31, 1996 is inflated to July 1, 1997 using the growth computed in subsection (1)(g)(C) of this rule.

(e) The relationship percentage determined in subsection (3)(d) of this rule shall be applied to the statewide weighted average cost per Medicaid day determined in subsection (3)(c) of this rule to determine the new basic rate as of subsequent rebasing years.

(3) On July 1 of each non-base year, the Basic Flat Rate Payment rate will be inflated by the annual change in the DRI Index, as measured in the previous 4th quarter. For example, in July 1998, maximum direct care rates will be inflated by the change in the DRI Index between the 4th quarter 1996 and the 4th quarter 1997.

411-070-0446 <u>Incentive to Contain Costs</u>

(1) In any rebasing year in which the rebased basic rate is less than the immediately preceding rebasing year basic rate after increase by the change in the DRI Index, the new basic rate shall be:

(a) The rebased basic rate; plus

(b) One-half the difference between

(A) The rebased basic rate; and

(B) The immediately preceding rebasing year basic rate, increased by the change in the DRI Index.

(2) Examples.

(a) For the 1999 rebasing year, the basic rate is $87 per day. The DRI Index increases by 3 percent per year in both 1999 and 2000. The 1999 basic rate, increased by the change in the DRI Index, is $92.30 as of July 1, 2001.

(b) The rebased basic rate computed per OAR 411-070-0440 is $92.00 as of July 1, 2001 which is less than $92.30. The weighted average rate is increased by one-half the difference between the 2001 basic rate increased by the change in the DRI Index ($92.30) and the 2001 rebased basic rate ($92.00). The 2001 basic rate equals $92.00 plus (one-half times ($92.30 minus $92.00)) equals $92.15 per day.

411-070-0452 <u>Pediatric Nursing Facilities</u>

(1) Pediatric Nursing Facility:

(a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21;

(b) A nursing facility that meets the criteria of subsection (1)(a) of this rule will be reimbursed as follows:

(A) It will be paid a per diem rate of $188.87 commencing on July 1, 1999. This is a prospective rate and is not subject to settlement;

(B) The per diem rate will be calculated as follows: The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days. Once the weighted average cost is determined, the rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to set the new rate. Before computing the weighted average

cost, the facility-specific total costs are inflated by a change in DRI Index to bring the cost to the rebase year.

(C) On July 1 of each non-rebase year after 199 9, the pediatric rate will be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate rebasing will occur in alternate years. Rebasing of pediatric nursing facility rates will be calculated using the method described in 1(b)(B) of this rule.

(c) Even though pediatric facilities will be reimbursed in accordance with subsection (1)(b) of this rule, pediatric facilities must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements.

(2) Licensed Nursing Facility With a Self-Contained Pediatric Unit:

(a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the care of pediatric residents and alternate uses must not interfere with the primary use;

(b) A nursing facility that meets the criteria of subsection (2)(a) of this rule will be reimbursed for its pediatric residents cared for in the pediatric unit at the per diem rate described in subsection (1)(b) of this rule commencing on July 1, 1999;

(c) Licensed nursing facilities with a self-contained pediatric unit shall comply with all requirements relating to the timely submission of Nursing Facility Financial Statements, and shall file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

411-070-0458 Minimum Wage Add-On

(1) Oregon law raised the minimum wage to $5.50 per hour, effective January 1, 1997; $6.00 per hour effective January 1, 1998; and $6.50 per hour effective January 1, 1999. An add-on to the basic rate and to the pediatric rate will be calculated to reflect the cost of implementing the minimum wage in facilities.

(2) The add-on for minimum wage implementation is effective January 1, 1997.

(a) The add-on to be paid during 1997 will reflect the cost of implementation of increasing the minimum wage from $4.75 per hour to $5.50 per hour.

(b) The add-on to be paid during 1998 will reflect the cost of implementation of increasing the minimum wage from $5.50 per hour to $6.00 per hour. The add-on to be paid during 1998 will also include costs required to be paid as a result of 1997 implementation.

(c) The add-on to be paid from January 1, 1999 through June 30, 1999 will reflect the cost of implementation of increasing the minimum wage from $6.00 per hour to $6.50 per hour. The add-on to be paid during January 1 through June 30, 1999 will also include costs required to be paid as a result of 1997 and 1998 implementation.

(d) The basic rate will be rebased effective July 1, 1999, based on audited facility costs during the fiscal period ending June 30, 1998. The 1999 rebasing will recognize facility costs incurred as a result of 1997 minimum wage implementation and as a result of minimum wage implementation from January 1 through June 30, 1998.

(e) The add-on to be paid from July 1, 1999 through June 30, 2001 will reflect the cost of implementation of increasing the minimum

wage from $5.50 per hour to $6.00 per hour from July 1 to December 1, 1998, and from $6.00 per hour to $6.50 per hour effective January 1, 1999. The add-on will be paid through June 30, 2001.

(f) The add-on to be paid will be inflated effective each July 1 by the change in the DRI index as measured in the previous 4th quarter. For example, in July 1998, the add-on being paid will be inflated by the change in the DRI Index between the 4th quarter 1996 and the 4th quarter 1997.

(3) The add-on to be paid from January 1, 1997 through June 30, 1997 will be added to the June 30, 1997 settlement rate for each facility and will not be limited by the maximum rate. The addition of the add-on cannot result in a facility being paid more than its actual cost per resident day.

(4) The add-on to be paid from July 1, 1997 through June 30, 2001 will be calculated as a weighted average add-on to be paid to all nursing facilities. The add-on will be paid in addition to the basic rate and the pediatric rate.

(5) Facilities supplied December, 1996 payroll data to SDSD to be used in the computation of the 1997 add-on. Facilities that did not supply payroll data to the Division will not receive any add-on for minimum wage increases between January 1, 1997 and June 30, 1997. Facilities that did not supply payroll data to the Division will be counted as not having any costs related to implementation of the minimum wage for calculation of the weighted average add-on to be paid between July 1, 1997 and December 31, 1997.

(6) Facilities will be requested to supply payroll data to the Division for computation of the 1998 and 1999 implementation costs during September, 1998 and September, 1999, respectively. Payroll data must be received by the Division within 45 days of the date of its written request to be included in calculation of the add-on.

411-070-0462 <u>Long Term Care Upper Limit</u>

(1) The Division will establish upper limit adjustment payments to each non-State operated governmental nursing facility.

(2) The upper limit adjustment shall be paid at least annually for each State Fiscal Year. The payment to each facility is in proportion to the facility's Medicaid days during the cost reporting period that ended immediately preceding the State Fiscal Year, relative to the sum of all Medicaid days during the same period for facilities eligible and participating in the adjustment. The total funds for the adjustment are established each State Fiscal Year subject to the anticipated level of nursing facility payments within the Year and to the payment limits of 42 CFR 447.272.

411-070-0464 Final Report

(1) FINAL REPORTS. When a provider agreement is terminated for any reason, the provider shall submit final reports in accordance with OAR 411-070-0300. Full payment for the month during which the provider agreement is terminated will not be made by the Division until final reports are received and desk reviewed. The Division will initially pay the provider the excess by which the payment for the month in which the provider agreement is terminated exceeds the maximum amount the Division can penalize a provider under OAR 411-070-0300(2)(c). The remainder of the payment shall be made by the Division after receipt and desk review of final reports.

(2) Settlement rates based on Nursing Facility Financial Statements submitted for the period that ends June 30, 1997 shall be calculated as defined by these rules as they existed on June 30, 1997.

411-070-0465 Uniform Chart of Accounts

The following account definitions shall be used to classify the dollar amounts on the Nursing Facility Financial Statement (NFFS). The account balance is to be reported in whole dollars under the facility gross column on the NFFS and referenced by the providers' chart of accounts number. It is the provider's responsibility to ensure that the balances reported reconcile to

their fiscal year statements and general ledger balances with any differences explained on Schedule A to Form SDS 35 or SDS 35A. The provider is responsible for making adjustments to these accounts for non-allowable items and amounts using the adjustment column to arrive at the net allowable balance. Each adjustment is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(1) Current Assets - The following accounts include cash and other assets reasonably expected to be realized in cash or sold, or consumed during the normal nursing facility operating cycle, or within one year when the operating cycle is less than one year.

(a) 101 - Cash on Hand - This account balance represents the amount of cash on hand for petty cash funds.

(b) 102 - Cash in Bank - This account balance represents the amount in a bank checking account.

(c) 103 - Cash in Savings - This account balance represents the amount accumulated in a savings account.

(d) 104 - Resident Cash - This account balance represents the amount of resident funds entrusted to the provider and held as cash on hand in the bank.

(e) 109 - Accounts Receivable - This account balance represents the amounts due from or due on behalf of all residents at the end of the fiscal period being reported.

(f) 110 - Notes Receivable - This account balance represents the current balance of amounts owed to the facility (payee) that are covered by a written promise to pay at a specified time, and is signed and dated by the maker.

(g) 111 - Allowance for Doubtful Accounts - This account balance represents amounts owed to the facility and estimated to be uncollectible.

(h) 115 - Employee Advances - This account balance represents amounts paid in advance to employees for salaries or wages that will be liquidated in the next payroll cycle following the closing date of the financial statement.

(i) 120 - Inventory Nursing Supplies - This account balance represents the cost value of supplies on hand at the end of the reporting period, to be used in providing nursing care.

(j) 122 - Inventory Food - This account represents the cost value of food that is on hand at the end of the reporting period.

(k) 124 - Inventory - Other Supplies - This account balance represents the cost value of general operating supplies, such as laundry, housekeeping and maintenance supplies that are on hand at the end of the reporting period.

(l) 125 - Prepaid Expenses - This account balance represents the cost value of paid expenses not yet incurred covering regularly recurring costs of operation like rent, interest, and insurance.

(m) 149 - Other Current Assets - This account balance comprises all current assets not identified above. Each item in this account, including short-term savings certificates, must be explained on Schedule A to Form SDS 35 or SDS 35A.

(2) Non-Current Assets - The balances of the following accounts represent Assets not recognized as current.

(a) 151 - Land - This account balance represents the acquisition cost and other costs, like legal fees and excavation costs, which are incurred to put the land in condition for its intended use.

(b) 153 - Building(s) - This account balance represents the acquisition cost of permanent structures and property owned by the provider used to house residents. It includes the purchase or contract price of all permanent buildings and fixed equipment attached to and forming a permanent part of the building(s).

(c) 154 - Allowance for Depreciation - This account balance represents the accumulation of provisions made to record the expiration in the building(s) life attributable to wear and tear through use, lapse of time, obsolescence, inadequacy or other physical or functional cause. The straight line method is the only recognized depreciation method for cost reimbursement.

(d) 155 - Land Improvements - This account balance represents the acquisition cost of permanent improvements, other than buildings, which add value to the land. It includes the purchase or contract price.

(e) 156 - Allowance for Depreciation - This account is of the same nature and is used in the same manner as Account 154.

(f) 157 - Building Improvements - This account balance represents the acquisition cost of additions or improvements which either add value to or increase the usefulness of the building(s). It includes the purchase or contract price.

(g) 158 - Allowance for Depreciation - This account is of the same nature and is used in the same manner as Account 154.

(h) 161 - Equipment - This account balance represents the acquisition cost of tangible property of a permanent nature, other than land, building(s) or improvements, used to carry on the nursing facility operations. It includes the purchase or contract price.

(i) 162 - Allowance for Depreciation - This account is of the same nature and is used in the same manner as Account 154.

(j) 165 - Leasehold Improvements - This account balance represents the acquisition cost of any long-lived improvements or additions to the property being leased which will belong to the owner (lessor) at the expiration of the lease.

(k) 166 - Allowance for Amortization - This account is of the same

nature and is used in the same manner as Account 154 except the cost of improvements or additions shall be amortized over the lesser of the expected benefit life or the remaining life of the lease.

(l) 181 - Investments - This account balance represents the value of assets unrelated to the nursing facility operation. The detail of this account shall be explained on Schedule A to Form SDS 35 or SDS 35A.

(m) 187 - Goodwill - This account balance represents the value of goodwill identified with the purchase of assets.

(n) 199 - Other - Non-Current Assets - This account balance comprises all non-current assets not identified above. Each item in this account, including long-term savings certificates, must be explained on Schedule A to Form SDS 35 or SDS 35A.

(3) Current Liabilities - The balances of the following accounts are considered current liabilities.

(a) 201 - Accounts Payable - This account balance represents the liabilities for goods and services received but unpaid at the end of the reporting period.

(b) 202 - Accounts Payable - Resident Account - This account balance represents the amount owed to residents for the cash entrusted to the facility in Account 104.

(c) 203 - Notes Payable - Other - This account balance represents the current portion of the amount owed by the facility that is covered by a written promise to pay at a specified time and is signed and dated by the facility (maker).

(d) 204 - Notes Payable to Owner - This account balance represents notes payable to the owner(s) and is of the same nature and is used in the same manner as Account 203.

(e) 205 - Accrued Interest Payable - This account balance

represents the liabilities for interest accrued at the end of the reporting period but not payable until a later date.

(f) 207 - Other Accrued Payable - This account is of the same accrual nature and is used in the same manner as Account 205 and is to be explained in detail on Schedule A to Form SDS 35 or SDS 35A.

(g) 208 - Payroll Payable - This account balance is the accrued payroll, less withheld payroll taxes and other deductions, payable to employees at the end of the reporting period.

(h) 217 - Payroll Tax Payable - This account balance is the employer's share of accrued payroll taxes payable at the end of the reporting period.

(i) 218 - Payroll Deductions Payable - This account balance is the employee's share of accrued payroll taxes withheld from the employer's gross pay payable at the end of the reporting period.

(j) 219 - Deferred Income - This account balance represents the liability for revenue collected in advance.

(k) 229 - Other Current Liabilities - This account balance comprises all current liabilities not identified above. The nature and purpose of amounts included in this account shall be explained on Schedule A to Form SDS 35 or SDS 35A.

(4) Long-Term Liabilities - The balances of the following accounts are considered long-term liabilities.

(a) 231 - Long-Term Mortgage Payable - This account balance represents the amount owed by the facility that is secured by a mortgage or other contractual agreement providing for conveyance of property at a future date.

(b) 233 - Long-Term Notes Payable - This account is of the same nature and is used in the same manner as Account 203 except

the liability extends beyond one year.

(c) 234 - Long-Term Notes Payable Owner - This account is of the same nature and is used in the same manner as Account 204 except the liability extends beyond one year.

(d) 249 - Other Long-Term Liabilities - This account comprises all long-term liabilities not identified above. The amount and nature of items in this account shall be explained on Schedule A to Form SDS 35 or SDS 35A.

(5) Net Worth - The balances of the following accounts represent the amount by which the facility's assets exceed its liabilities.

(a) 251 - Capital Stock - This account balance represents the amount of cash or property received in exchange for the corporation's capital stock.

(b) 255 - Retained Earnings - This account balance represents the amount of capital resulting from retention of corporate earnings.

(c) 261 - Capital Account - This account balance represents the book value of the proprietor or partner(s) equity in the facility.

(d) 265 - Drawing Account - This account balance represents the owners withdrawals of funds during the reporting period that were not paid as part of the payroll.

(e) 290 - Net Profit (Loss) - This account balance is the facility's revenue minus expenses for the reporting period.

(6) Resident Revenue - These accounts include revenue for routine service charges exclusive of ancillary charges. The intent is for revenue to be reported in gross, exclusive of any cost offsets. Routine service charges are to be reported in the following accounts:

(a) For cost reports filed for periods that end prior to July 1, 1997:
(A) 301A - Private Resident - NF Payment Category 4 - This

account includes revenue for NF Payment Category 4 routine private resident care.

(B) 301B - Private Resident - NF Payment Category 2 - This account includes revenue for NF Payment Category 2 routine private resident care.

(C) 301C - Private Resident - Other - This account includes revenue for other than private NF Payment Category 4 or 2 residents and is to be explained on Schedule A to Form SDS 35 or SDS 35A. Private heavy cost resident revenue would be included in this account.

(D) 302A - Medicaid Resident - NF Payment Category 4 - This account includes revenue from all sources for NF Payment Category 4 Medicaid residents.

(E) 302B - Medicaid Resident - NF Payment Category 5 - This account includes revenue from all sources for NF Payment Category 5 Medicaid Residents.

(F) 302C - Medicaid Resident - NF Payment Category 2 - This account includes revenue from all sources for NF Payment Category 2 Medicaid residents.

(G) 302D - Medicaid Resident - NF Payment Category 3 - This account includes revenue from all sources for NF Payment Category 3 Medicaid residents.

(H) 302E - Medicaid Resident - NF Payment Category 1 - This account includes revenue from all sources for NF Payment Category 1 Medicaid residents.

(I) 302F - Medicaid - Other - This account includes revenue for Medicaid resident care from all sources other than NF Payment Categories 1 through 5 and is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(J) 303 - Medicare Resident - This account includes revenue from all sources for Medicare resident care.

(K) 304 - Other Governmental Resident - This account includes revenue from all sources for governmental program resident care other than Medicaid or Medicare and is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(b) For cost reports filed for periods that end on and after July 1, 1997:

(A) 301A - Private Resident - Complex Medical Needs - This account includes revenue for Complex Medical Needs routine private resident care. These are private pay residents whose medical needs correspond to the Medicaid complex medical needs criteria.

(B) 301B - Private Resident - Basic Rate - This account includes revenue for basic rate routine private resident care. These are private pay residents whose medical needs correspond to the Medicaid basic rate needs criteria.

(C) 301C - Private Resident - Other - This account includes revenue for other than private Complex Medical Needs and Basic Rate residents and is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(D) 302A - Medicaid Resident - Complex Medical Needs - This account includes revenue from all sources for Complex Medical Needs Medicaid residents.

(E) 302B - Medicaid Resident - Pediatric - This account includes revenue from all sources for Pediatric Medicaid Residents.

(F) 302C - Medicaid Resident - Basic Rate - This account includes revenue from all sources for Basic Rate Medicaid

residents.

(G) 302D - Medicaid Resident - NF Payment Category 1 - This account includes revenue from all sources for NF Payment Category 1 Medicaid residents.

(H) 302E - Medicaid - Other - This account includes revenue for Medicaid resident care from all sources other than NF Payment Categories 1, Basic Rate, Complex Medical Needs and Pediatric and is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(I) 303 - Medicare Resident - This account includes revenue from all sources for Medicare resident care.

(J) 304 - Other Governmental Resident - This account includes revenue from all sources for governmental program resident care other than Medicaid or Medicare and is to be explained on Schedule A to Form SDS 35 or SDS 35A.

(7) Ancillary Revenue - These accounts include revenue for professional and non-professional services and supplies not included in Section (6) of this rule. Revenue other than that described above shall be reported as gross revenue and related expenses to be reported in the appropriate expense accounts. Ancillary service charges are to be reported in the following accounts:

(a) 323 - Nursing Supplies - This account includes revenue from the sale of nursing supplies or services.

(b) 328 - Prescription Drugs - This account includes revenue from the sale of prescription drugs.

(c) 329 - Laboratory - This account includes revenue from laboratory services provided.

(d) 330 - Physical Therapy - This account includes revenue from

physical therapy services provided.

(e) 331 - Speech Therapy - This account includes revenue from speech therapy services.

(f) 332 - Occupational Therapy - This account includes revenue from occupational therapy services.

(g) 341 - X-Ray - This account includes revenue from X-Ray services.

(h) 351 - Personal Purchases - This account includes revenue from residents for personal purchases.

(i) 361 - Barber and Beauty - This account includes revenue from residents for barber and beautician services.

(j) 399 - Other Ancillary - Items and amounts included in this account shall be described on Schedule A to Form SDS 35 or SDS 35A.

(8) Other Revenue - These accounts include other revenue, exclusive of resident and ancillary revenue. The intent is for revenue to be reported in gross and the related expenses reported in the appropriate expense accounts. Other revenues are classified as follows:

(a) 803 - Grants - This account includes revenue amounts received in the reporting period from public and privately funded grants and awards.

(b) 805 - Donations - This account includes donations in the form of cash or goods and services received during the reporting period.

(c) 811 - Interest - This account includes revenue from any interest bearing note, bank account, or certificate.

(d) 813 - Staff & Guest Food Sales - This account includes revenue from facility food sales to individuals other than residents of the

facility.

(e) 814 - Concession Sales - This account includes revenue from vending machines or for resale items not reported in Accounts 813 and 351.

(f) 815 - Equipment Rental Income - This account includes revenue from equipment rentals.

(g) 819 - Miscellaneous Other Revenue - Items and amounts, including revenues for Nurse Aide Training and Competency Evaluation, Mental Health revenues received from local governments, and Workers Compensation refunds, included in this account are to be described on Schedule A to Form SDS 35 or SDS 35A.

(9) Property Expenses - These accounts are for reporting property expenses.

(a) 452 - Interest - This account is for reporting all interest expense except other interest expense in Account 439.

(b) 453 - Rent Building - This account is for reporting all building rent or lease expenses.

(c) 454 - Leased Equipment - This account is for reporting all equipment rental and lease expense, except for other operating support and oxygen concentrators.

(d) 455 - Depreciation - Building - This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 153.

(e) 456 - Depreciation - Land Improvement - This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 155.

(f) 457 - Depreciation - Building Improvement - This account is for

reporting depreciation, for the reporting period, associated with assets capitalized in Account 157.

(g) 458 - Depreciation - Equipment - This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 161.

(h) 459 - Amortization - Leasehold Improvement - This account is for reporting amortization, for the reporting period, associated with assets capitalized in Account 165 and Account 166.

(i) 461 - Miscellaneous - Property - This account is for reporting other property costs, such as amortization of organizational costs, and items of equipment less than $1,000 that are for general use.

(10) Administrative and General Expenses - These accounts report expenses for administration of the facility and the business office, and items not readily associated with other departments.

(a) 411 - Compensation - Administrator - This account is for reporting all the compensation received by the licensed administrator of the facility. Compensation includes salary, bonuses, auto, moving, travel and all other allowances paid directly or indirectly by the facility.

(b) 412 - Compensation - Assistant Administrator - This account is to be used for reporting all compensation of the individual who is identified as, and has the specific duties of, Assistant Administrator.

(c) 415 - Compensation - Other Administrative - This account is for reporting all of the compensation received by administrative, clerical, secretarial, accounting, supply and personnel.

(d) 443B - Employee Benefits and Taxes - This account is for reporting the allocated portion of Account 443 attributable to administrative compensation expenses.

(e) 420 - Concession Expense - This account is for reporting expenses of non-medical, non-resident care items sold to the residents and non-residents including items sold through vending machines.

(f) 422 - Funeral & Cemetery Supplies & Services - This account is for reporting all expenditures associated with funeral and cemetery supplies and services.

(g) 423 - Personal Purchase - This account is for reporting all expenditures for personal items purchased for individual residents.

(h) 425 - Office Supplies - This account is for reporting expenses of all office supplies except those chargeable to Account 625. Materials include stationery, postage, printing, bookkeeping supplies, and office supplies.

(i) 426 - Communications - This account is for reporting all telephone, telegraph service, communication, cable television fees and paging system charges.

(j) 427 - Travel - This account is for reporting all transportation costs associated with vehicles used for resident care or resident recreation, exclusive of insurance and depreciation and for reporting all other travel expenses such as lodging and meals for conferences, conventions, workshops, or training sessions.

(k) 429 - Advertising - Help Wanted - This account is for reporting all help wanted advertising expense.

(l) 430 - Advertising - Promotional - This account is for reporting all expenditures of the facility related to promotional advertising including yellow page advertising.

(m) 431 - Public Relations - This account is for reporting all expenditures related to public relations.

(n) 432 - Licenses, Dues & Subscriptions - This account is for reporting all fees for facility licenses; dues in professional associations; and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff use.

(o) 433 - Accounting & Related Data Processing - This account is for reporting all accounting, payroll, and other data and report processing expenses.

(p) 435 - Legal Fees - This account is for reporting all legal fees and expenses. Legal fees shall be reported in conformance with OAR 411-070-0359(1)(t).

(q) 436 - Management Fees - This account is for reporting all management fees charged to the facility, including management salaries and benefits at the home office.

(r) 439 - Other Interest Expense - This account is for reporting interest expense not attributable to the purchase of the facility and equipment.

(s) 441 - Bad Debts - This account is for reporting the expense recorded from recognizing a certain portion of accounts receivable as uncollectible.

(t) 445C - Education & Training - This account is for reporting registration, tuition, materials, and manual costs for training the staff included in Accounts 411, 412, 415, and 433.

(u) 446 - Contributions - This account is for reporting the expense of any gift or donation.

(v) 449 - Miscellaneous - This account is for reporting general administrative operating expenses not specifically included in other general administrative operating expense accounts. Entries shall be explained in detail on Schedule A to Form SDS 35 or SDS 35A.

(11) Other Operating Support Expenses - The following accounts are included in this category.

(a) 443D, 443E, 443F, 443G - Employee Benefits and Taxes - This account is for reporting the allocated portion of Account 443 identified with Repair and Maintenance Salaries in Account 511, dietary salaries in Account 521, laundry salaries in Account 531, and housekeeping salaries in Account 541.

(b) 451 - Real Estate & Personal Property Taxes - This account is for reporting real estate and personal property tax expenses for the facility.

(c) 460 - Insurance - This account is for reporting all insurance expenses other than employee insurance expenses reportable in Account 440, Payroll Taxes, and Account 442, Employee Benefits.

(d) 511 - Compensation - Maintenance & Repair Employees - This account is for reporting all compensation received by employee(s) responsible for providing facility repair and maintenance.

(e) 512 - Heat & Electricity - This account is for reporting all facility heating and lighting expenses.

(f) 515 - Water, Sewer and Garbage - This account is for reporting all water, sewer and garbage expenses.

(g) 516 - Maintenance Supplies & Services - This account is for reporting all expenses required for building and equipment maintenance and repairs including preventative maintenance and not capitalized. All balances in Accounts 516E, 516F, 516G, and 516I will be consolidated in Account 516D prior to submission to the Division.

(h) 521 - Compensation - Dietary Employees - This account is for

reporting all compensation received by employee(s) providing dietary services.

(i) 527 - Purchased Services - This account is for reporting all non-employee services required in the dietary, laundry and housekeeping department operations including dietary consulting expenses.

(j) 528 - Dietary Supplies - This account is for reporting the expense of all supplies, dishes and utensils, and non-capitalized equipment utilized within this department, exclusive of food.

(k) 531 - Compensation - Laundry Employees - This account is for reporting all compensation received by employees responsible for providing laundry services.

(l) 532 - Linen and Bedding - This account is for reporting the expense of all linen and bedding utilized within the facility.

(m) 538 - Laundry Supplies - This account is for reporting the expense of all supplies utilized by the laundry.

(n) 541 - Housekeeping Salaries - This account is for reporting all compensation received by employees responsible for providing housekeeping services.

(o) 548 - Housekeeping Supplies - This account is for reporting the expense of all supplies utilized to provide housekeeping services.

(p) 549 - Miscellaneous - This account is for reporting other operating support expenses not specifically included in an identified account, including lease and rent expenses attributable to other operating support services. Entries shall be explained in detail on Schedule A to Form SDS 35 or SDS 35A.

(12) Food

522 Food - This account is for reporting all food products and

supplements used in food preparations.

(13) Direct Care Operating Expenses - These accounts include compensation, supplies and services used in providing direct resident care.

(a) Compensation

(A) 443H Employee Benefits & Taxes - This account is for reporting the allocated portion of Account 443 attributable to this area.

(B) 601 Compensation - Director of Nursing Services - This account is for reporting all compensation received by employee(s) responsible for directing the nursing services of the facility.

(C) 611 Compensation - Registered Nurses - This account is for reporting all compensation received by registered nurse employees of the facility who provide nursing care, other than the Director of Nursing Services. If a Registered Nurse provides nursing care part of the time and carries out other duties the rest of the time, this employee's compensation shall be allocated to the appropriate account based on time spent on each activity.

(D) 621 Compensation - Licensed Practical Nurses - This account is for reporting all compensation received by Licensed Practical or Licensed Vocational Nurse employees of the facility who provide nursing care. If a Licensed Practical Nurse provides nursing care part of the time and carries out other duties the rest of the time, this employee's compensation shall be allocated to the appropriate account based on time spent on each activity.

(E) 631 Compensation - Other Nursing Employees - This account is for reporting all compensation received by aides, attendants, orderlies and other non-licensed,

non-professional employees who provide nursing care. If such employees provide nursing care part of the time and carry out other duties the rest of the time, these employees' compensation shall be allocated to the appropriate account based on time spent on each activity.

(F) 701 Compensation - Physicians - This account is for reporting all compensation received by physicians providing resident medical care.

(G) 711 Compensation - Pharmacy Employees - This account is for reporting all compensation of licensed pharmacists and technicians employed by the facility.

(H) 721 Compensation - Laboratory Employees - This account is for reporting all compensation of pathologists and technicians employed by the facility to provide laboratory services.

(I) 731 Compensation - X-Ray Employees - This account is for reporting all compensation of radiologists and technicians employed by the facility to provide X-Ray services.

(J) 741 Compensation - Activities & Recreational Employees - This account is for reporting all compensation of employees engaged in the planning and carrying out of resident recreational activities.

(K) 742 Compensation - Social Workers - This account is for reporting all compensation of social workers and assistants employed to provide social service activities.

(L) 751 Compensation - Rehabilitation Employees - This account is for reporting all compensation of occupational and physical therapists, and technicians, and aides employed to provide resident rehabilitation activities or services. This account shall be subdivided in accordance with OAR 411-070-0359(3)(g) on Schedule A to Form SDS

35 or SDS 35A.

(M) 761 Compensation - Religious Employees - This account is for reporting all compensation for individuals employed who provide religious services.

(N) 771 Compensation - Other Service Employees - This account is for reporting all compensation for ward clerks and medical records clerks employed by the facility.

(O) 781 Compensation - Other Employees - This account is for reporting all compensation for dentists, barbers, beauticians, research, and other non-identified personnel employed by the facility and shall be explained in detail on Schedule A to Form SDS 35 or SDS 35A.

(P) 787 Purchased Services - This account is for reporting the expense attributable to employment agencies that provide part-time employees on a fee and salary basis for direct care. The expenses shall be allocated to the appropriate payroll account in the adjustment column.

(b) Direct Care Supplies and Services

(A) 625 - Medical Records Supplies - This account is restricted to materials used in resident charting.

(B) 445I - Education & Training - This account is for reporting registration, tuition, and book expense associated with education and training of direct care personnel.

(C) 629 - Nursing Supplies - This account is for reporting all medical supplies consumed by this department, exclusive of oxygen, used in providing direct care.

(D) 639 - Oxygen Supplies - This account is for reporting the expense of all oxygen (gas) and concentrator rentals.

(E) 646 - Nursing Assistant (Aide) Training and Competency Evaluation - This account is for reporting all expenses associated with OAR 411-070-0470 (which excludes salaries of nurse aide trainees).

(F) 719 - Physician Fees - This account is for reporting all expenditures for physician treatment, care and evaluation of the resident.

(G) 723 - Drugs and Pharmaceuticals - Nursing Home - This account is for reporting all expenditures meeting the criteria of 411-070-0085(2)(j).

(H) 728 - Drugs & Pharmaceuticals - Prescriptions - This account is for reporting all expenditures for legend drugs and biologicals prescribed by a licensed physician and not meeting the criteria of 411-070-0090.

(I) 729 - Pharmacy Supplies - This account is for reporting the expense of all materials utilized in the facility pharmacy operation.

(J) 739 - Laboratory Supplies & Fees - This account is for reporting the expense of all materials utilized in the facility laboratory operation and fees paid for non-employee pathologist and laboratory technician services.

(K) 749 - X-Ray Supplies & Fees - This account is for reporting the expense of all materials utilized in the facility X-Ray department and fees for non-employee radiologists and X-Ray technician services.

(L) 759 - Activities & Recreational Supplies - This account is for reporting the expense of all materials, except transportation, used in providing resident recreational activities.

(M) 769 - Rehabilitation Supplies & Fees - This account is for reporting the expense of all materials used in providing occupational and physical therapy including fees for

non-employee related services. This account shall be subdivided in accordance with OAR 411-070-0359(3)(I) on Schedule A to Form SDS 35 or SDS 35A.

(N) 782 - Utilization Review - This account is for reporting the expenses of all non-employee fees associated with utilization review.

(O) 789 - Consultants - This account is for reporting all expenditures for consultant fees, including travel and lodging, exclusive of dietary and management consultants and shall be explained in detail on Schedule A to Form SDS 35 or SDS 35A.

(P) 799 - Miscellaneous - Expenses reported in this account, including supplies for barber and beauty, shall be explained in detail on Schedule A to Form SDS 35 or SDS 35A. The cost of non-employee Barber and Beautician services will be reported in this account.

(14) Payroll Taxes & Employee Benefits - These accounts are for reporting payroll taxes and employee benefits.

(a) 440 - Payroll Taxes - This account is for reporting all of the employer's portion of payroll taxes, including FICA, unemployment, Workers Compensation and other payroll taxes not withheld from the employee's pay.

(b) 442 - Employee Benefits - This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners and gifts. Established vacation, holiday and sick pay programs and child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account.

(c) 443 - Employee Benefits and Taxes - This account is for reporting the sum of Accounts 440 and 442 and is allocated to

the specific sub-accounts by actual cost of the payroll category, or by percentage of the payroll category amount to the total facility payroll.

(d) These costs may be allocated on a percentage basis equivalent to the payroll distribution or on an actual basis by cost center. All facility payroll taxes and employee benefits will be allocated by the same method, if actual is not used.

411-070-0470 Nursing Assistant Training and Competency Evaluation Programs Cost Reports

(1) COST REPORT REQUIRED. Medicaid certified facilities shall file a Nursing Assistant Training and Competency Evaluation Program (NATCEP) cost report quarterly with the Division's Financial Audit Unit that meets the following standards:

(a) Due Date, Period. A NATCEP cost report is due and shall be postmarked by the last day of the calendar quarter subsequent to the quarter which it covers (or postmarked the first business day after the quarter if the last day of the quarter is a Sunday or holiday). The cost report shall identify all costs incurred and related revenues (not including NATCEP payments from the Division) received during the reporting period. If a facility fails to file a report postmarked as described, NATCEP reimbursement shall be reduced by three percent for each business day the report is past due until received.

(b) Format and Content. A cost report shall:

(A) Be submitted on a form provided by the Division;

(B) Include actual costs incurred and paid by the facility. The Division shall not reimburse a facility prospectively;

(C) Include all revenue (not including NATCEP payments from the Division) received by the facility for conducting nurse aide training. All revenue shall be used to offset the costs incurred and paid in the period;

(D) Include appropriate documentation to support each specific area identified for payment by the state; for example, invoices for equipment purchases or to reimburse contract trainers, time sheet for qualified facility training staff, evidence an aide paid for NATCEP and was reimbursed by the facility as specified in section (2) of this rule. Failure to provide required documentation will result in the form being rejected and returned to the facility;

(E) Include all appropriate NATCEP costs and revenues only. NATCEP costs, including costs disallowed, shall not be reimbursed as part of the facility's all-inclusive rate; however, NATCEP costs, revenues and reimbursement must be included on the facility's annual Nursing Facility Financial Statement; and

(F) Include only true and accurate information. If a facility knowingly or with reason to know files a report containing false information, such action shall constitute cause for termination of the facility's provider agreement with the Division. Providers filing false reports may be referred for prosecution under applicable statutes.

(2) CHARGING OF FEES PROHIBITED. The nursing facility shall not charge a trainee any fee for participation in NATCEP or for any textbooks or other materials required for NATCEP if the trainee is employed by or has an offer of employment from a nursing facility on the date on which the NATCEP begins.

(3) FEES PAID BY EMPLOYER.

(a) All charges and materials required for NATCEP and fees for nursing assistant certification shall be paid by the nursing facility if it offered employment at the facility on the date training began.

(b) If a nursing assistant who is not employed by a Medicaid certified facility and does not have an offer of employment by a Medicaid nursing facility on the date on which the NATCEP began

becomes employed by or receives an offer for employment from a nursing facility within twelve months after completing a NATCEP, the employing facility shall reimburse the Certified Nursing Assistant (CNA) on a monthly basis for any NATCEP fees paid (including any fees for textbooks or other required course materials) by the CNA. Evidence the nurse aide paid for training shall include the graduation certificate from the school and receipt of payment.

(A) Such reimbursement shall be calculated on a pro rata basis. The reimbursement shall be determined by dividing the cost paid by the nursing assistant by 12 and multiplying by the number of months during this twelve-month period in which the aide worked for the facility. The facility shall claim the appropriate pro rata amount on each report it submits not to exceed the lesser of 12 months or the total number of months the CNA was employed at that facility. The facility shall submit evidence provided by the CNA of the training costs incurred at an approved training facility.

(B) Example 1: If a CNA incurred a cost of $120, received an offer of employment during the NATCEP, was employed by a facility for nine months immediately following the completion of the NATCEP, but terminated employment after those nine months, the facility would be required to reimburse the CNA $10 per month for nine months: $120 divided by 12 months equals $10/month.

(C) Example 2: If a CNA incurred a cost of $282, was not employed by Medicaid facility "A" until two months after completion of NATCEP, continued such employment for seven months, then went to work for Medicaid facility "B" for three or more months, facility "A" would be required to reimburse the CNA $23.50 per month during the seven months of employment; facility "B" would continue to reimburse the CNA $23.50/month for three months: 282 divided by 12 months equals $23.50/month. Each facility must provide evidence the CNA paid for the NATCEP

training.

(4) REIMBURSEMENT BY DIVISION. The Division shall reimburse the facility for the Medicaid portion of the costs described in this section unless limited by the application of section (5). This portion is calculated by multiplying the eligible costs paid by the facility by the percentage of resident days which are attributable to Medicaid clients during the reporting period. The Division's payment to the facility for the NATCEP cost is in addition to payments based upon the facility's all-inclusive rate.

(a) Employee Compensation. Reimbursement for trainer hours shall not exceed 1 1/3 times the number of hours required for certification. (For example, currently the Board of Nursing requires 70 classroom hours and 50 clinical hours for a total of 120 training hours and maximum student to instructor ratios of 20 to 1 for classroom sessions and 10 to 1 for clinical sessions. For a class in which no more than 10 students are enrolled at the completion of the first 30 hours of classroom training, the Division would allow one set of classroom hours and one set of clinical hours for a total of 160 hours - 120 hours times 1 1/3. For class in which 11 to 20 students are enrolled at the completion of the first 30 hours of classroom training, the Division would allow one set of classroom hours and two sets of clinical hours for a total of 226 2/3 - 170 hours times 1 1/3. For a class in which 21 to 30 students are enrolled at the completion of the first 30 hours of classroom training, the Division would allow two sets of classroom hours and three sets of clinical hours for a total of 386 2/3 - 290 times 1 1/3.) A facility may claim reimbursement for the portion of an employee's compensation attributable to nurse aide training if:

(A) The employee meets the qualifications of 42 CFR 483.152 and OAR 851-60-070 (licensed nursing personnel or persons licensed in other health care professions);

(B) The employee directly conducts training or testing in a certified program;

(C) The employee's compensation, including benefits, is commensurate with other RN compensation paid by the facility;

(D) The employee's total compensated hours do not exceed 40 in any week during which NATCEP reimbursement is claimed;

(E) No portion of the claimed reimbursement is for providing direct care services while assisting in the training of nurse aides if providing direct care services is within the normal duties of the employee; and

(F) The facility provides the Division with satisfactory documentation to support the methodology for allocating costs between facility operation and NATCEP.

(b) Training Space and Utilities. Costs associated with space and utilities are eligible only if the space and utilities are devoted 100 percent to the NATCEP. The facility must provide documentation satisfactory to the Division to support the need for and use of the space and utilities.

(c) Textbooks and Course Materials. A portion of the cost of textbooks and materials is eligible if textbooks and materials are used primarily for NATCEP. The portion reimbursable is equal to the percentage of use attributable to NATCEP. "Primarily" means more than 50%. The facility must provide satisfactory documentation supporting the NATCEP need for and percentage of use of textbooks and materials.

(d) Equipment. A portion of the cost of equipment is eligible if used primarily for NATCEP. However, equipment purchased for $500 or more per item must be prior approved by the Division to qualify for reimbursement. The portion reimbursable is equal to the percentage of use attributable to NATCEP. "Primarily" means more than 50%. The facility must provide satisfactory

documentation supporting the NATCEP need for and percentage of use of the equipment. Disposition of equipment and software purchased in whole or in part under the Title XIX Medicaid Program shall meet the requirements of the facility's provider agreement.

(e) Certification Fees. Nursing assistant certification and recertification fees paid to the Oregon State Board of Nursing for facility employees are eligible.

(f) Reimbursement for CNAs. Reimbursement provided to nursing assistants pursuant to section (3) of this rule is eligible. The training must have occurred at an approved training center, including nursing facilities in Oregon or other states.

(g) Contract Trainers. Payment for nurse aide certification classes provided under contract by persons who meet the qualifications of 42 CFR 483.152 is eligible for reimbursement. For this purpose, either the facility or the contractor must be certified for NATCEP. Allowable contract trainer payments will be limited to the lesser of actual cost or the salary calculation described in subsection (4)(a) of this rule.

(h) Ineligible Costs - Trainee Wages. Wages paid to nursing assistants in training are not eligible for NATCEP reimbursement, but may be claimed as part of the daily reimbursement costs.

(i) Reimbursement for Combined Classes. If two or more Medicaid certified facilities cooperate to conduct nurse aide training, the Division shall not reimburse any participating facility for the combined training class until all participating facilities have filed a cost report. For a combined class, the Division shall apportion reimbursement to participating facilities pro rata based on the number of students enrolled at the completion of the first 30 hours of classroom training or in any other equitable manner agreed to by the participating facilities. However, when cooperating facilities file separate NATCEP cost reports, nothing

in this subsection authorizes the Division to deny or limit reimbursement to a facility based on a failure to file or a delay in filing by a cooperating facility.

(5) (a) Notwithstanding section (4) of this rule, the Division shall calculate the 80th percentile of the Medicaid portion of reported NATCEP costs per trainee completing the training. If a facility's Medicaid portion exceeds the 80th percentile of costs, the Division shall evaluate the facility's NATCEP costs to determine whether its costs are necessary due to compelling circumstances including, but not limited to:

(A) Rural or isolated location of the training facility;

(B) Critical client care need;

(C) Shortage of certified nursing aides available in the local labor market; or

(D) Absence or inadequacy of other training facilities or alternative training programs, e.g., community college certification programs.

(b) If, under the analysis in subsection (5)(a) of this rule, the Division finds that a facility's NATCEP costs are justified, the Division shall reimburse the reported costs pursuant to section (4) of this rule. However, if, under the analysis in subsection (5)(a) of this rule, the Division finds that a facility's NATCEP costs are not justified, the Division shall reimburse the reported costs pursuant to section (4) of this rule, but limited by the cost plateau.

(6) (a) Recordkeeping, Audit and Appeal. The facility shall maintain supportive documentation for a period of not less than three years following the date of submission of the NATCEP cost report. This documentation shall include records in sufficient detail to substantiate the data reported. If there are unresolved audit questions at the end of the three-year period, the records must be maintained until the questions are resolved. The

records shall be maintained in a condition that can be audited.

(b) The Division will analyze by desk review each timely filed and properly completed NATCEP cost report. All cost reports are also subject to field audit at the discretion of the Division. The facility will be notified in writing of the amount to be reimbursed and of any adjustments to the cost statement. Settlement of any amounts due to the Division must be made within 30 days of the date of notification to the facility.

(c) A facility is entitled to an informal conference and contested case hearing pursuant to ORS 183.413 through 183.470, as described in OAR 411-070-0435, to protest the reimbursement amount or the adjustment. If no request for an informal conference or contested case hearing is made within 30 days, the decision becomes final.