Document: Final Rule, **Register Page Number:** 26 IR 706
Source: December 1, 2002, Indiana Register, Volume 26, Number 3
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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-13(F)

DIGEST

Amends 405 IAC 1-14.6-2, 405 IAC 1-14.6-4, 405 IAC 1-14.6-6, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, 405 IAC 1-14.6-12, 405 IAC 1-14.6-16, and 405 IAC 1-14.6-22 to revise the case mix reimbursement methodology that the Medicaid program utilizes to reimburse nursing facilities as follows: removes from consideration as allowable cost indirect costs associated with ancillary services provided to non-Medicaid residents; establishes a children's nursing facility designation for Medicaid reimbursement purposes and removes the profit add-on portion of the direct care component for nursing facilities not designated as children's nursing facilities; establishes a minimum occupancy parameter for the direct care, indirect care, and administrative rate components; provides for rebasing of Medicaid payment rates every other year, rather than annually; and updates mortgage interest rate parameter used to establish Medicaid reimbursement for capital costs of nursing facilities. Effective 30 days after filing with the secretary of state.

405 IAC 1-14.6-2 **405 IAC 1-14.6-9**
405 IAC 1-14.6-4 **405 IAC 1-14.6-12**
405 IAC 1-14.6-6 **405 IAC 1-14.6-16**
405 IAC 1-14.6-7 **405 IAC 1-14.6-22**

SECTION 1. 405 IAC 1-14.6-2, AS AMENDED AT 25 IR 2462, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 16-10-1

Sec. 2. (a) As used in this rule, "administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including directors fees) for patient-related services.
(2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) Travel.
(7) Telephone.
(8) License dues and subscriptions.
(9) Office supplies.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.

(15) Qualified mental retardation professional (QMRP).

(b) As used in this rule, "allowable per patient day cost" means a ratio between allowable cost and patient days.

(c) As used in this rule, "annual financial report" refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(d) As used in this rule, "allowable cost determination" means a computation performed by the office or its contractor to determine a nursing facility's per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

~~(d)~~ **(e)** As used in this rule, "average allowable cost of the median patient day **applicable to providers with an actual occupancy rate of at least sixty-five percent (65%)"** means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis **using each provider's actual occupancy from the most recently completed annual financial report** and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(f) As used in this rule, "average allowable cost of the median patient day applicable to providers with an actual occupancy rate of less than sixty-five percent (65%)" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of sixty-five percent (65%), or each provider's actual occupancy rate from the most recently completed annual financial report, and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

~~(e)~~ **(g)** As used in this rule, "average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

~~(f)~~ **(h)** As used in this rule, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

~~(g)~~ **(i)** As used in this rule, "capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:
(1) The fair rental value allowance.
(2) Property taxes.
(3) Property insurance.

~~(h)~~ **(j)** As used in this rule, "case mix index" (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:
(1) Medicaid residents.
(2) All residents.

~~(i)~~ **(k)** As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by

the office.

(l) As used in this rule, "children's nursing facility" means a nursing facility that has twenty-five percent (25%) or more of its residents who are under the chronological age of twenty-one (21) years and has received written approval from the office to be designated as a children's nursing facility.

~~(j)~~ **(m)** As used in this rule, "delinquent MDS resident assessment" means an assessment that is ~~not electronically transmitted by the fifteenth day of the second month following the end of a calendar quarter, or an assessment that is not electronically transmitted by the fifteenth day of the second month following the end of a calendar quarter, or an assessment that is~~ greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. **This determination is made on the fifteenth (15th) day of the second (2nd) month following the end of a calendar quarter.**

~~(k)~~ **(n)** As used in this rule, "desk ~~audit"~~ **review"** means a review ~~of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.~~ **and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.**

~~(l)~~ **(o)** As used in this rule, "direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all:

(1) nursing and nursing aide services;
(2) nurse consulting services;
(3) pharmacy consultants;
(4) medical director services;
(5) nurse aide training;
(6) medical supplies;
(7) oxygen; and
(8) medical records costs.

~~(m)~~ **(p)** As used in this rule, "fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

~~(n)~~ **(q)** As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

~~(o)~~ **(r)** As used in this rule, "forms prescribed by the office" means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

~~(p)~~ **(s)** As used in this rule, "general line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

~~(q)~~ **(t)** As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(r)~~ **(u)** As used in this rule, "incomplete MDS resident assessment" means an assessment that ~~does not contain all data items that are required to classify a resident pursuant to the RUG-III resident classification system, for example, MDS RUG fields that include blanks, out of range, or inconsistent responses, or an assessment that~~ is not printed by the nursing facility provider upon request by the office or its contractor.

~~(s)~~ **(v)** As used in this rule, "indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Allowable dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.

~~(t)~~ **(w)** As used in this rule, "minimum data set (MDS)" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration.

~~(u)~~ **(x)** As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients.

(y) As used in this rule, "non-rebasing year" means the year during which a nursing facility's annual Medicaid rate is not established based on a review of its annual financial report covering its most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate components from the previous year by an inflation adjustment. The following year shall be a non-rebasing year: July 1, 2003, through June 30, 2004.

~~(v)~~ **(z)** As used in this rule, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average case mix index (CMI) for all residents.

~~(w)~~ **(aa)** As used in this rule, "office" means the office of Medicaid policy and planning.

~~(x)~~ **(bb)** As used in this rule, "ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

~~(y)~~ **(cc)** As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

~~(z)~~ **(dd)** As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(ee) As used in this rule, "rebasing year" means the year during which a nursing facility's Medicaid rate is based on a review of its annual financial report covering its most recently completed historical period. The following years shall be rebasing years:

July 1, 2002, through June 30, 2003
July 1, 2004, through June 30, 2005
And every year thereafter.

~~(aa)~~ **(ff)** As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

~~(bb)~~ **(gg)** As used in this rule, "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI and facility-average CMI for Medicaid residents.

~~(cc)~~ **(hh)** As used in this rule, "therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

~~(dd)~~ **(ii)** As used in this rule, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

~~(ee)~~ **(jj)** As used in this rule, "unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system ~~is~~ **are** not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15, **and such data items result in the assessment being classified into a different RUG-III category.**

~~(ff)~~ **(kk)** As used in this rule, "untimely MDS resident assessment" means a significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707)*

SECTION 2. 405 IAC 1-14.6-4, AS AMENDED AT 25 IR 2465, SECTION 3, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ~~ninety (90) days~~ **the last day of the fifth (5th) calendar month** after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider **and must coincide with the fiscal year end for Medicare cost reporting purposes.** If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. **Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic cost report (ECR) file copy of their Medicare cost report that covers their most recently completed historical reporting period. Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.**

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with

that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than ~~ninety (90) days~~ **the last day of the fifth (5th) calendar month** after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. ~~Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's~~ **Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic ECR file copy of their Medicare cost report that covers their most recently completed historical** reporting ~~year.~~ **period.**

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(10) Copy of the working trial balance that was used in the preparation of their submitted Medicare cost report.

(d) Extension of the ~~ninety (90) day~~ **five (5) month** filing period shall not be granted. ~~unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.~~

(e) Failure to submit an annual financial report **or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services** within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent ~~report is~~ **reports are** received.

(2) When an annual financial report **or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services** is ~~thirty (30) days~~ **more than one (1) calendar month** past due, ~~and an extension has not been granted,~~ the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the **seventh (7th)** month following the ~~thirtieth day the annual financial report is past due,~~ **provider's fiscal year end** and shall so remain until the first day of the month after the delinquent annual financial report **or Medicare cost report (if required)** is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. **If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the provider fails to submit their Medicare cost report to the office on or before the due**

date as extended by the Medicare fiscal intermediary, then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the new operation is not currently enrolled or submitting MDS assessments under the Medicare program and the provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or transfer to hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or transfer to hospital.

(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has ~~transmitted~~ incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has untimely MDS resident assessments, then such assessment(s) shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).

(k) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office or its contractor shall audit a sample of MDS resident assessments and will determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the sample that are unsupported is greater than the threshold percent as shown in column (B) of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the **field portion of the** MDS audit and no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on all residents, the office or its contractor will determine the percent of assessments audited that are unsupported.

(4) If the percent of assessments of all residents that are unsupported is greater than the threshold percent as shown in column (B) of the table below, a corrective remedy shall apply, which shall be calculated as follows. The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below. In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments of all residents that are unsupported is equal to or less than the threshold percent

as shown in column (B) of the table below, the office or its contractor shall conclude the **MDS** audit and no corrective remedy shall apply.

(6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table in this subdivision, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

Effective Date (A)	Threshold Percent (B)	Administrative Component Corrective Remedy Percent (C)
October 1, 2002	40%	5%
January 1, 2004	30%	10%
April 1, 2005	20%	15%

(l) Based on findings from the MDS audit, beginning on the effective date of this rule, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(m) Beginning on the effective date of this rule, upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709)*

SECTION 3. 405 IAC 1-14.6-6, AS AMENDED AT 25 IR 2468, SECTION 5, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-6 Active providers; rate review

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative, and capital components, **which are applicable to the facility based on their actual occupancy rate from the most recently completed historical period,** shall **only** be determined ~~once per~~ **during a rebasing** year for each provider for the purpose of performing the provider's annual rate review.

(b) **The annual rate review that shall become effective during a rebasing year shall be established by determining** the normalized allowable per patient day cost for **the** direct care **component,** and the allowable per patient day costs for the therapy, indirect care, administrative, and capital components ~~shall be established once per year~~ for each provider based on the annual financial report.

(c) The annual rate review that shall become effective during a non-rebasing year shall be established by applying an inflation adjustment to the previous year's indirect care, administrative, capital, and therapy Medicaid rate components. The direct care component of the annual rate review during a non-rebasing year shall be established by applying an inflation adjustment to the previous year's normalized allowable cost and applying the Medicaid case mix adjustment as prescribed by this rule. The inflation adjustment

prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	**July 1, Year 1**
April 1, Year 1	**October 1, Year 1**
July 1, Year 1	**January 1, Year 2**
October 1, Year 1	**April 1, Year 2**

~~(c)~~ **(d)** The rate effective date of the annual rate review **during rebasing years and non-rebasing years** shall be the first day of the second calendar quarter following the provider's reporting year end.

~~(d)~~ **(e)** Subsequent to the annual rate review **established during rebasing years and non-rebasing years,** the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

~~(e)~~ **(f)** The case mix index for Medicaid residents in each facility shall be updated each calendar quarter and shall be used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

~~(f)~~ **(g)** All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

~~(g) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712)*

SECTION 4. 405 IAC 1-14.6-7, AS AMENDED AT 25 IR 2468, SECTION 6, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review **during a rebasing year,** each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the ~~Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF)~~ **CMS Nursing Home without Capital Market Basket** index as published by ~~DRI/McGraw-Hill.~~ **DRI/WEFA.** The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year	July 1, Year 1

April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning on the effective date of this rule through September 30, 2003, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, 2003, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months **for use in establishing the annual rebasing year rate review,** the previous provider's most recently completed annual financial report ~~for which a rate has been established~~ shall be utilized to calculate the new provider's first annual **rebasing year** rate review. The inflation adjustment for the new provider's first annual **rebasing year** rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

~~(d) The normalized average allowable cost of the median patient day for direct care costs and the average allowable cost of the median patient day for indirect care, administrative and capital-related costs shall not be less than the average allowable cost of the median patient day effective October 1, 1998.~~

(d) Allowable costs per patient day for direct care, indirect care, and administrative costs shall be computed based on an occupancy rate equal to the greater of sixty-five percent (65%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the month following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the sixty-five percent (65%) minimum occupancy requirement, if the following conditions can be established to the satisfaction of the office:

(1) the provider demonstrates that its current resident census has increased to sixty-five percent (65%) or greater since the facility's fiscal year end of the cost report used to establish its Medicaid rate during the most recent rebasing year and has remained at such level for no less than ninety (90) days; and

(2) the provider demonstrates that its resident census has increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the cost report used to establish its Medicaid rate during the most recent rebasing year.

~~(e)~~ **(f)** Allowable costs per patient day for capital-related costs shall be computed based on an occupancy ~~level~~ **rate** equal to the greater of ninety-five percent (95%) or the provider's actual occupancy **rate** from the most recently completed historical period.

~~(f)~~ **(g)** The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

	~~RUG-II~~ **RUG-III**	
RUG-III Group	Code	CMI Table
~~Special~~ Rehabilitation	RAD	2.02
~~Special~~ Rehabilitation	RAC	1.69

~~Special~~ Rehabilitation	RAB	1.50
~~Special~~ Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

~~(g)~~ **(h)** The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports serve as confirmation of the MDS assessments transmitted by the nursing facility and provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments. The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

~~(h)~~ **(i)** The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to such facilities at

a rate of eight dollars and seventy-nine cents ($8.79) per Medicaid resident day. **Such additional reimbursement shall be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents and shall remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712)*

SECTION 5. 405 IAC 1-14.6-9, AS AMENDED AT 25 IR 2470, SECTION 7, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The indirect care, administrative, and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable per patient day **direct therapy** costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day **direct care** costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(b) The profit add-on payment will be calculated as follows:

(1) For **nursing facilities designated by the office as children's nursing facilities,** the direct care component ~~the~~ profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs **applicable to the facility based on its actual occupancy rate from the most recently completed historical period,** times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) ~~a~~ **the** provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(2) Beginning on the effective date of this rule, and continuing for eight (8) full calendar quarters thereafter, for nursing facilities that are not designated by the office as children's nursing facilities, the direct care component profit add-on is equal to zero (0). Beginning on the first day of the ninth (9th) full calendar quarter after the effective date of this rule, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

~~(2) For~~ **(3)** The indirect care component ~~the~~ profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day **applicable to the facility based on its actual occupancy rate from the most recently completed historical period,** times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

~~(3) For~~ **(4)** The administrative component ~~the~~ profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day **applicable to the facility based on its actual**

occupancy rate from the most recently completed historical period, times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

~~(4) For~~ **(5)** The capital component ~~the~~ profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus

(B) a provider's allowable per patient day cost.

~~(5) For~~ **(6)** The therapy component ~~the~~ profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs **applicable to the facility based on its actual occupancy rate from the most recently completed historical period,** times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).

(2) The average allowable cost of the median patient day for indirect care costs **applicable to the facility based on its actual occupancy rate from the most recently completed historical period,** times one hundred percent (100%).

(3) The average allowable cost of the median patient day for administrative costs **applicable to the facility based on its actual occupancy rate from the most recently completed historical period,** times one hundred percent (100%).

(4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).

(5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714)*

SECTION 6. 405 IAC 1-14.6-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

(1) The fair rental value allowance is calculated by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based

on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined above is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined above is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-12; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; filed Sep 1, 2000, 2:10 p.m.: 24 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 715)

SECTION 7. 405 IAC 1-14.6-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-16 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall apply cost allocation principles established by the federal Medicare cost report methodology based on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall apply cost allocation principles established by the federal Medicare cost report methodology based on a statewide average ratio of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-16; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716)*

SECTION 8. 405 IAC 1-14.6-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate **and allowable cost determinations** after ~~such rate has~~ **they have** been computed. If the provider disagrees with the rate ~~determination~~ **or allowable cost determinations,** the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate **or allowable cost determinations as** computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or **allowable cost** determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with a rate **or allowable cost** redetermination resulting from a financial audit adjustment or reportable condition affecting a rate **or allowable cost redetermination,** the provider must request an administrative reconsideration from the Medicaid financial audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate **or allowable cost redeterminations** computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the MDS audit contractor shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the MDS audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716)*

SECTION 9. **If the provisions in this document are not already in effect under an emergency rulemaking**

action, then the following shall apply. For purposes of implementing the revisions to 405 IAC 1-14.6 contained in this document, the following shall apply:

(1) Reimbursement rates for all Medicaid certified nursing facilities shall be calculated effective on the effective date of this document. The office or its designee shall calculate a new rate for each nursing facility under this document based on the most recent submitted and completed cost report filed under 405 IAC 1-14.6. Subsequent quarterly changes to a nursing facility's rate will be made as prescribed by this document and 405 IAC 1-14.6.

(2) The average inflated allowable cost of the median patient day and the historical cost of property of the median bed used to calculate reimbursement rates shall be established on the effective date of this document using the most recent cost report data for which a Medicaid rate is established as of the effective date of this document. Subsequent revisions to these parameters shall be made as prescribed by this document.

(3) The case mix indices (CMIs) shall be recalculated using the 5.12, 34-grouper version of the Resource Utilization Group, version III (RUG-III) based on the same MDS data that was previously used to establish the CMIs using the 5.01, 44-grouper version of the RUG-III.

(4) For purposes of implementing SECTION 7 of this document, the office or its contractor shall use the most recent Medicare cost report that has been submitted to the Medicare fiscal intermediary. For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that fail to timely submit their Medicare cost report upon request, the office or its contractor shall determine the portion of such facility's costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services based on a statewide average ratio of indirect costs to direct costs for such therapy and ancillary services, as determined from Medicare cost reports of nursing facilities that timely submit their Medicare cost report.

LSA Document #02-13(F)
Notice of Intent Published: 25 IR 1670
Proposed Rule Published: June 1, 2002; 25 IR 2779
Hearing Held: June 25, 2002
Approved by Attorney General: September 23, 2002
Approved by Governor: September 30, 2002
Filed with Secretary of State: October 10, 2002, 10:47 a.m.
Incorporated Documents Filed with Secretary of State: None