Rule No. 560-X-42-.04 Medicaid Per Diem Rate Computation Methodology

(1) All ICF/~~/MR~~IID providers will be grouped into two (2) functional categories:
(a) ICF/~~MRs~~IIDs larger than 15 beds.
(b) ICF/~~MRs~~IIDs (15 beds or less).

(2) Within each grouping, the following methodology shall apply: cost reports, as submitted, will be desk audited for any unallowable costs, and those costs will be removed from the subsequent computations. The providers' reported allowable costs will be used as the basis for calculating new per diem rates. The following methodology will be used for determining the per diem rates for approved beds.

(a) Net reported costs (Schedule B, Column 5 of the cost report) shall be adjusted for cost recovery items, unallowable cost and excess administrative costs.

(b) Costs as adjusted in (a) above (less any property cost) shall be separated into Salaries and other cost. The Other cost will be multiplied by the Medicaid inflation index to calculate a budgeted increase in other expense. To determine a projected increase in salaries, the amount or % increase specified by the provider shall be used.

(c) Budgeted increases/decreases (rent, depreciation, interest, major repairs) shall be calculated using as a basis data supplied by the provider.

(d) In lieu of depreciation, a use allowance shall be determined for buildings and improvements for State owned and operated facilities.

(e) The allowable equity capital will be multiplied by the percentage rate of return specified in Rule No. 560-X-42-.13 and the product will be the allowance for Return on Equity Capital. (This allowance applies to proprietary providers only.)

(f) The sum of the amounts as determined in (a) - (e) above shall be divided by total resident days as reported by the provider. The resulting average cost per day will be arrayed within each of the two functional groupings of facilities. The number of facilities in each grouping will be multiplied by 90% to determine the position of the facility that represents the 90th percentile. If the 90th percentile does not fall on a whole number, the Agency will round up or down to the nearest whole number. If the number falls on a .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Counting from the bottom of the array (upward) that facility's cost in each grouping will be the ceiling reimbursement rate for all costs of the homes within that functional class.

Example:

1. Net Reported Costs (Schedule B, Column 5)
2. Deduct: Cost recovery items, unallowable cost, excess administrative compensation.
3. a. Separate Cost (less property cost) into salary and other cost.
   b. Calculate the budgeted increase for sala ries, add to salaries.
   c. Multiply other cost by the Medicaid infla tion index, add to other cost.
   d. Add: Any budgeted increases/decreases (Rent, depreciation, interest,

major repairs, add back property cost (if applicable) that was deducted in (a) above.

e. In lieu of depreciation, a use allowance for buildings and improvements shall be determined for State owned and operated facilities and added to cost as adjusted in (a) - (d) above.

f. Add allowance for return on equity (if applicable).

g. Total items (b) - (f) above. Divide this sum by total resident days as reported by the provider.

h. Determination of 90th percentile ceiling rate based on array of amounts in Item g for all providers within the group ing.

(3) Computation of a per diem rate for unapproved beds will follow the methodology as set out in sections 1 - 2 above, except that no return on equity capital will be allowed with respect to such unapproved beds. Also, there will be no depreciation, use allowance, interest, taxes or other such costs allocable to unapproved beds.

(4) Ceilings Not Subject to Adjustments. Once the percentile ceilings have been established for a fiscal year, they will be final and not normally subject to revision or adjustment during that year. Since the ceiling rates are based on information provided in the cost reports, it is to the benefit of each provider to insure that the provider's information is correct and accurate. If obvious errors are detected during the desk audit process, providers will be given an opportunity to submit corrected data.

(5) After the rates have been set, each provider will be notified of its rate. If the provider has questions regarding any disallowances made during the rate setting process, they may request further information in writing. Only those requests submitted in writing will be honored.

(6) The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for residents in the facility for a full month. For partial month coverage, the per diem rate is multiplied times the number of days.

(7) Dollar values are rounded.

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