

Title 20. Public Health and Welfare

Chapter XV. Division of Medical Services, Department of Human Services

Subchapter A. Generally

Part 579. Medical Assistance Program Manual of Cost Reimbursement Rules for Long-Term Care Facilities

Codification Notes. This part as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"Introduction

This manual is for use by providers, their accountants and the Department of Human Services in determining the allowable and reasonable cost of Long Term Care services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Department of Human Services.

The Long Term Care Program is administered by the Division of Medical Services. The program herein adopted is in accordance with Federal Statute in the Social Security Act § 1902 (a) (13) (A) and Public Law 105-33. The applicable Federal Regulations begin at 42 Code of Federal Regulations § 430. Each Long Term Care Facility which has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this manual and must file the required cost reports.

As interpretations and changes of this program are made, appropriate revisions of the manual will be furnished to each provider and interested party. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions relating to this program or relating to the interpretation of any of the provisions included in this manual should be addressed to:

Department of Human Services

Division of Medical Services

P. O. Box 1437, Slot S535
Little Rock, AR 72203-1437"

Subpart 1. Principles and Procedures

20 CAR § 579-101. General principles.

(a)(1) All long-term care facilities will be reimbursed according to the principles and procedures specified in this part.

(2) Allowable costs are those costs necessary and reasonable for performance of covered services required by Medicaid recipients.

(b)(1) A facility's direct and indirect allowable costs related to covered services will be considered in the findings and allocation of costs to the medical assistance program for its eligible recipients.

(2) Total allowable, reasonable costs after removal of direct Medicare ancillary cost of a facility shall be apportioned on a per resident day basis between third-party payers and other residents so that the share borne by Medicaid under Title XIX is based upon actual services and costs related to medical assistance recipients.

(c) Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated facilities to comply with all requirements of participation in the Medicaid program.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-102. Recordkeeping.

(a)(1) Providers are required to maintain adequate financial records and statistical data for proper determination of costs payable under the program.

(2) The cost report is to be based on financial and statistical records maintained by the facility.

(3) Cost information must be current, accurate, and in sufficient detail to support costs set forth in the report.

(4) This includes all ledgers, books, records, and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, basis for apportioning costs, etc.) which pertain to the determination of reasonable costs.

(5) A provider must make available, within the state, all financial and statistical records to the Department of Human Services or its representatives for the purpose of determining compliance with the provisions of this program.

(6) Providers who find it difficult to provide home office records at the audit or review site can, at their option, reimburse the department for all costs associated with the travel of department employees or their representatives in accordance with state laws and rules for the reimbursement of travel for state employees.

(b)(1) The financial and statistical report/cost report and schedules sets forth information to be reported.

(2) The report must be prepared on the accrual basis of accounting in accordance with instructions for completion of the cost report.

(3) Government facilities have the option to use the cash basis of accounting for reporting.

(c) All financial and statistical records, including cost reports, must be retained for a period of five (5) years after submission to the department.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-103. Activities not related to resident care.

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-104. Accrual and cash basis of accounting.

(a)(1) For nongovernmental providers, the financial and statistical report must be

filed using information stated on the accrual method of accounting.

(2) The chart of accounts is designed to be used in a complete accrual accounting system.

(b)(1) Financial information stated on an accrual basis is essential to ensure that the proper reimbursement is made to providers.

(2) The measurement of the cost of services performed must include all supplies, salaries, services, and other expenses incurred, regardless of whether or not those items have been paid.

(c)(1) Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads.

(2) Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system.

(3) Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his or her records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-105. Chart of accounts.

(a) The applicable chart of accounts shall be used by all long-term care facilities participating in the Title XIX program.

(b) Each chart of accounts provides for the basic classifications of all assets, liabilities, income, and expense necessary for the preparation of the cost report.

(c) Providers may take some latitude in assigning account numbers but must maintain the basic chart of accounts.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-106. Cost reporting requirements.

(a)(1)(A) All providers in operation under a valid Medicaid agreement for long-term care services must file a financial and statistical report, commonly referred to as a "cost report" or "FSR".

(B) In addition to the annual reporting requirement, nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001, to June 30, 2001, in order that the direct care per diem can be rebased after this initial period.

(2)(A) Nursing facilities that have been newly constructed or a newly enrolled provider that did not previously participate in Medicaid will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

(B) This report is essential in establishing rates for a new provider.

(C) If the facility was not certified for Medicaid participation at date of first opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition.

(3) Nursing facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end of the state fiscal year unless the cost reporting period would be less than three (3) months of operation.

(4) Facilities that change ownership after April 1 of a state fiscal year would not submit a cost report from the date of initial operation to the end of the state fiscal year.

(5) Facilities changing ownership after April 1 of a state fiscal year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

(b) **When to file.**

(1)(A)(i) Nursing facilities will report cost on a fiscal year ending June 30.

(ii) Cost reports will be due within ninety (90) days after the end of the reporting period.

(B)(i) Under sixteen-bed intermediate care facilities for individuals with

intellectual disabilities (ICF/IID) providers will report cost on a calendar year basis.

(ii) The cost report will be due within ninety (90) days of the end of the reporting period.

(C)(i) The Arkansas Health Center Nursing Facility and the sixteen-bed and over ICF/IID providers will report cost semiannually, January 1 – June 30 and July 1 – December 31, with the cost reports being due within sixty (60) days of the end of the reporting period.

(ii) Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day.

(D) Nursing facility cost reports are to be electronically submitted through the LTC cost report web application on or before the applicable due date.

(E) ICF/IID reports are to be delivered, postmarked, or electronically uploaded to the web portal on or before the applicable due date.

(2)(A) Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D violation of Arkansas Code § 20-10-205.

(B) Civil penalties associated with failure to timely submit a cost report for long-term care facilities are detailed in 20 CAR § 579-111.

(c) Extensions for filing.

(1) If a written request for an extension is received by the Division of Medical Services in advance of the report due date and a written extension is granted, a penalty will not be applied provided the extended due date is met.

(2) Each request for extension will be considered on its merit.

(3) No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report.

(4) In no instance will an extension be granted for more than thirty (30) days.

(d) What to submit.

(1) In addition to the applicable cost report forms, providers must submit the following:

(A) Most recently completed Medicare cost report;

(B) Working trial balance and related working papers identifying the cost report line each account is included on;

(C) Detailed depreciation schedule;

(D) Any work papers used to compute adjustments made on the cost report;

(E) A copy of any new or amended contracts for management services by a related party, home office, or a third party which includes the basis used to allocate the costs to providers of the group and to nonprovider activities, if applicable; and

(F) Copy of new or amended lease agreement if a leased facility.

(2)(A) When it is determined, upon initial review for completeness by the division, that a cost report has been submitted without all required information, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report.

(B)(i) For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information.

(ii) For cost reports which are submitted by an extended due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information.

(C) If requested additional information has not been submitted by the specified date, the cost report will be subject to the penalty provisions for delinquent submission.

(D)(i) An exception exists in the event that the due date, or extended due date when an extension has been granted, comes after the specified number of days for submission of the requested information.

(ii) In these cases, the provider will be allowed to submit the additional requested information on or before the due date, or extended due date if an extension has been granted, of the cost report.

(e) **Where to submit.**

(1) Nursing facility cost reports and additional information should be submitted through the LTC cost report web application.

(2) ICF/IID cost reports and additional information may be submitted to the address below or uploaded to the contractor's web portal:

Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437 - Slot S535
Little Rock, AR 72203-1437

(f) **Amended cost reports.** Providers can submit amended cost reports to the Department of Human Services up to one hundred eighty (180) days after the close of the cost reporting period.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Codification Notes. "LTC" means long-term care.

20 CAR § 579-107. Desk reviews.

(a)(1) The Department of Human Services will review all cost reports to verify that all facilities have submitted reports properly and in compliance with this manual.

(2) Providers will be notified in writing of the results of the desk review.

(b) A provider's cost report can be adjusted for any errors or unallowable costs identified on a provider's cost report after the initial desk review has been completed up to the last day of the rate year for which rates are based on the adjusted cost report.

(c) Financial and statistical reports, financial records, statistical records, and any other pertinent documents will be analyzed to verify that:

(1) Cost reports are complete, accurate, and consistent with previous periods and in compliance with program policy;

(2) The allowable costs are necessary, allocable, and reasonable for the

performance of covered services required by Medicaid recipients;

(3) The costs are authorized and are not prohibited under federal and state laws, rules, and regulations;

(4) The costs are accorded consistent treatment through the application of accounting principles and practices appropriate to the circumstances;

(5) The costs are related to resident care;

(6) The costs and statistics included in the financial and statistical report are accurate and applicable to the current period; and

(7) The costs are net of all applicable credits.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-108. Audits of financial records.

(a)(1) The Department of Human Services will provide for periodic audits of some or all cost reports and supporting records.

(2) The department may also conduct limited reviews of cost data and/or client statistics reported in the cost reports.

(b)(1) The auditors will issue a report upon completion of each audit or review.

(2) The report will reflect cost and statistical information as submitted in the cost report and any adjustments the auditors recommend, such that the information complies with the criteria listed above.

(3) All audit reports will state the auditor's opinion as to whether, in all material respects, the cost information reported on the schedule of expenses (DHS-750, Form 5 or DOM-400, Form 6) and total actual resident days reported on the statistical data schedule (DHS-750, Form 2 or DOM-400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy, rules, and regulations.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-109. Unauditable situations.

(a)(1) If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a "disclaimer" report signifying that the audit could not be accomplished.

(2) The Office of Long-Term Care will advise the facility of the disclaimer in writing.

(b) A period of ninety (90) days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation.

(c)(1) A follow-up audit will be attempted upon expiration of the ninety-day period or sooner if requested by the facility.

(2) If the audit cannot be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately.

(3) A period of thirty (30) days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients.

(4) The appeals procedures specified in 20 CAR § 579-110 are available to providers.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-110. Appeal procedures.

(a) Time limit for appeals.

(1)(A) Any long-term care facility may appeal the facility's reimbursement rate, a recoupment, a cost disallowance, a fine, a sanction, the imposition of a civil money penalty, or suspension or termination from the program by submitting a written notice of appeal to the Secretary of the Department of Human Services within thirty (30) calendar days following the date of the appealed action.

(B) The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation.

(C) If the facility wishes to utilize the mediation process as contained in this section, it must so state in its written notice of appeal.

(2)(A)(i) If an appeal is filed, the secretary or his or her designee will appoint an independent hearing officer to hear the appeal.

(ii) The hearing officer will schedule all appeals within sixty (60) days of receipt of written notice of appeal by the Division of Medical Services and will notify the parties in writing of the hearing schedule.

(iii)(a) Provided that if the appealing facility states in its written notice of appeal that it wishes to utilize the mediation processes and the department agrees, then the time for the secretary or his or her designee to appoint a hearing officer is waived.

(b) However, the appealing facility and the secretary or his or her designee shall implement the mediation process within the sixty (60) days.

(c) Upon the termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved, the secretary or his or her designee will appoint the independent hearing officer within sixty (60) days of the termination.

(d) The hearing officer will set a discovery schedule if requested by either party. Either party may request a continuance for good cause.

(e) The hearing officer may grant a continuance for good cause upon motion of either party or on the hearing officer's own motion.

(f) The hearing officer will render a written decision within thirty (30) days of the hearing and furnish a copy of the decision to the parties or their representatives.

(B)(i) Any objection requesting disqualification of the hearing officer upon allegations of personal interest or bias must be made in writing, supported by good faith affidavit, and submitted to the secretary at least fifteen (15) days before the scheduled hearing.

(ii) The secretary will consider the objection promptly and rule on it in a timely manner.

(b) Administration of appeal.

(1)(A) The appellant may:

(i) Be present at the hearing;

- (ii) Be represented by counsel; and
- (iii) Call witnesses.

(B) The department may:

- (i) Appear by such officials as the division may deem necessary;
- (ii) Be represented by counsel; and
- (iii) Call witnesses.

(2)(A) All testimony shall be under oath.

(B) Each party shall have the right to:

- (i) Call and examine parties and witnesses;
- (ii) Introduce exhibits;
- (iii) Question opposing witnesses and parties on any matter relevant

to the issue; and

(iv) Rebut opposing evidence.

(C) The appellant shall have the burden of proving whatever facts it must establish to sustain its position by a preponderance of the evidence.

(3) The hearing officer shall conduct himself or herself in an impartial manner, and may question any party or witness at any time during the hearing.

(c) Decisions.

(1) All decisions rendered shall be submitted by the hearing officer in writing to the secretary for his or her review and final determination.

(2) At his or her discretion and for good cause, the secretary shall have the right to reverse a decision or to return the issue to the hearing officer for further consideration or additional findings of law or fact.

(3) All decisions by the hearing officer and the secretary shall contain findings of fact and law in accordance with applicable state and federal laws, rules, and regulations.

(4) The final decision shall be rendered in writing to the appellant.

(d) Mediation process.

(1)(A) If a long-term care facility in its written notice of appeal states it desires to utilize the mediation process in an attempt to resolve the dispute or disputes

between the facility and the department, as stated in the notice of appeal, and the department agrees to the mediation process, then mediation shall be utilized to clarify, narrow, or resolve the dispute or disputes.

(B) The department shall maintain a list of mediators supplied by the Arkansas Alternative Dispute Resolution Commission.

(C) The objective of the mediation process is to help each side in the dispute or disputes understand the other's point of view, with a goal of narrowing, clarifying, or resolving issues in dispute.

(D) If the dispute is or disputes are resolved as a result of mediation, then a written statement signed by both parties will be filed with the secretary or his or her designee, shall substitute for a decision in the case, and shall not be appealable.

(2)(A) The Office of Chief Counsel of the Department of Human Services shall submit a list of available mediators from which a mediator agreed to by both parties will be selected.

(B)(i) The mediator shall restrict his or her discussions to the designated representatives of the appealing facility and the designated representative of the department.

(ii) Designated representatives include each party's attorneys.

(C) The mediation shall not bind the parties.

(D) The mediation shall not add anything to the record except a final written agreement.

(E) The parties may add to the record, but only to the extent they both agree.

(F) The mediation shall not unduly delay the process of a case.

(G) Time limits for appointing a hearing officer and a decision shall be temporarily suspended during the mediation.

(H) The mediator shall ensure the parties are continuing to work towards resolution of the dispute.

(I) The negotiations shall be confidential and shall not be communicated to any decision makers who may serve as future hearing officers.

(J) If the mediation fails to produce an agreement or if mediation is not proceeding toward resolving the dispute, then the mediator or either party may so notify the secretary or his or her designee.

(K) The secretary or his or her designee will terminate the mediation whereupon the appeal will proceed as outlined in this section.

(3) The appealing facility and the department shall equally share the cost of the mediator's fee.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-111. Penalties for failure to comply with the Medicaid long-term care program.

(a)(1) By agreeing to participate in the long-term care program, providers must abide by this part.

(2) Participation in the program may be terminated should the provider:

(A) Fail to keep and maintain auditable records;

(B) Fail to disclose or make available to the Department of Human Services, or its authorized agent, records concerning the operation of the facility, including home office records, if applicable;

(C) Breach the terms of the Medicaid provider agreement or fail to comply with the terms of the provider's certifications set out on the Medicaid claim form;

(D) Charge or attempt to charge Medicaid recipients for Medicaid covered services over and above that paid by the department;

(E) Rebate or accept a fee or portion of a fee or charge for a Medicaid resident referral;

(F) Present, or cause to be presented, false information; and

(G) Submit, or cause to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled.

(3) In addition to the above listing of causes for termination, state or federal laws or rules may create requirements, the violation of which may cause adverse

action.

(b)(1) Arkansas Code § 20-10-205 classifies violations relating to the administration of long-term care facilities.

(2) Administrative and reporting requirements are classified as Class C and Class D violations.

(3) A description of each follows:

(A)(i) Class C violations: providers who fail to comply with administrative and reporting requirements that do not directly threaten the health, safety, or welfare of a resident have committed a Class C violation. Violations of this nature would include but are not limited to:

(a) Failure to provide resident assessment instruments in accordance with the prescribed submission policy. The resident assessment instrument must be complete to be considered submitted;

(b) Failure to maintain accurate census records in accordance with this part;

(c) Failure to maintain accurate resident trust fund records in accordance with this part; and

(d) Submission on the facility's cost report as allowable, costs determined by the department audit staff to have been claimed under circumstances identical in all material respects to costs that have been disallowed by final desk review or audit. A desk review or audit is final if no timely appeal has been filed or, if a timely appeal has been filed, there is a final appeal decision disallowing the cost. An appeal decision is final if no additional appeal is provided for by law, or if the time to file an additional appeal has expired. Any facility submitting as allowable costs, costs previously disallowed by a desk review or audit decision that is not final must identify each such cost and reference the pending appeal.

(ii) Class C violations are subject to a civil money penalty to be set by the Secretary of the Department of Human Services or his or her designee, in an amount not to exceed five hundred dollars (\$500) for a single violation. A single erroneous administrative or reporting practice will be considered a single violation

regardless of the number of resident records affected by the practice.

(B)(i) Class D violations: failure to timely submit the cost report for long-term care facilities. Cost reports must be postmarked on or before the due date or the extended due date in order to avoid a penalty. The failure to timely submit a cost report shall be considered a separate Class D violation during any month or part thereof of noncompliance.

(ii) Class D violations are subject to a civil money penalty to be set by the secretary or his or her designee, in an amount not to exceed two hundred fifty dollars (\$250) for each violation.

(iii) In addition to any civil money penalty which may be imposed, the Director of the Office of Long-Term Care is authorized after the first month of a Class D violation to withhold any further reimbursement to the long-term care facility until the cost report is received by the Office of Long-Term Care.

(c)(1) Any violation repeated within six (6) months subjects the facility to double civil money penalties up to a maximum of one thousand dollars (\$1,000) per violation.

(2) Assessment of civil money penalties does not limit the right of the Office of Long-Term Care to take such other action as may be authorized by law or rule.

(d) Providers violating this section may be referred to the office of the Attorney General.

Authority. Arkansas Code §§ 20-10-206, 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-112. Overpayments and underpayments.

(a)(1) Administrative errors on the part of the Division of Medical Services or the facilities may result in erroneous payments.

(2) These errors most commonly result from:

- (A) Failures to report a death, discharge, or transfer;
- (B) System error in resident classification; and
- (C) Miscalculations of recipient incomes.

(b)(1) Overpayments/underpayments resulting from these errors will be corrected

when discovered.

(2) Overpayments will be recouped by the division and underpayments will be reimbursed to the facility.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Subpart 2. Payment Method

20 CAR § 579-201. Generally.

Federal law requires that states use published payment methodologies and justifications which specify comprehensively the methods and standards for making Medicaid provider payments to long-term care facilities.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-202. Assurance of payment.

Certified Title XIX long-term care facilities furnishing services in accordance with all state and federal Medicaid laws and rules will be paid in accordance with rates established under the state Medicaid plan.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-203. Acceptance of payment.

Participation in the Title XIX program is limited to those facilities which agree to accept the Medicaid payment as payment in full for all care services provided to Medicaid recipients.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-204. Rate limitations based on Medicaid rates.

(a) The purpose of this provision is to ensure that the Medicaid program is not charged unfairly high rates as compared to other payers.

(b) To that end, Medicaid reimbursement is limited by the weighted average per diem rates charged to other payers.

(c) Specifically, if a long-term care facility charges other long-term care payers less than eighty percent (80%) of the Medicaid rate for long-term care services, except for those public facilities rendering long-term care services free of charge or at a nominal charge, then the weighted average Medicaid reimbursement will be reduced to no more than one hundred twenty-five percent (125%) of the facility's weighted average reimbursement.

(d) For purposes of applying this rule:

(1) Weighted average per diem rates for other payers will be compared to the weighted average Medicaid per diem rates by fiscal year;

(2) The sixty (60) consecutive days after a Medicaid rate increase shall not be considered; and

(3) No facility shall be required to make a retroactive rate adjustment.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-205. Facility class.

The Department of Human Services has established the following specific payment methods:

(1) **Nursing facilities.**

(A) Reimbursement methodology.

(i) Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four (4) major cost components and will be determined in the following way. Reimbursement rates will be determined by adding calculated per diem amounts for four (4) separate components of cost:

(a) Direct care;

(b) Indirect, administrative, and operating;

(c) Fair market rental; and

(d) The quality assurance fee.

(ii) This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with this part. Only full-year cost reports will be used in establishing cost ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative, and operating class rate.

(iii) The methodology for calculating the per diem amounts for each component of cost is provided below:

(a) Direct care.

(1) Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a ceiling.

(2) The ceiling shall be established at one hundred five percent (105%) of the allowable Medicaid direct care cost per diem incurred by the facility at the ninetieth percentile of arrayed Medicaid direct care facility cost.

(3) The direct care component of the rate will rebase annually for the period July 1 to June 30. An inflation index (see subdivision (1)(F) of this section) will be applied to the provider's direct care per diem cost to inflate cost from the cost reporting period to the rate period;

(b) Indirect, administrative, and operating. The per diem payment for this component will be set at one hundred ten percent (110%) of the median indirect, administrative, and operating per diem cost adjusted for inflation using the inflation index (see section (1)(F) of this section) and paid as a class rate to all facilities. This per diem payment will be rebased annually;

(c) Fair market rental.

(1) A fair market rental system will be used to reimburse property costs. The fair market rental system reduces the wide disparity in the cost of

property payments for basically the same service, therefore making this payment fairer to all participants in the program. The fair market rental system will be used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment, and major movable equipment used in providing resident care. The fair market rental payment for facilities that are leased from a related party will be calculated from the costs associated with the related party in conformity with related party regulations.

(2) The payment for provider property cost will be calculated annually by adding the return on equity, facility rental factor, and the cost of ownership, and dividing the sum of these three (3) components by the greater of the actual resident days or resident days calculated at the following occupancy levels. The minimum occupancy percentage for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year shall be sixty percent (60%). Thereafter, the minimum occupancy percentage shall increase as indicated in the following table, up to a maximum of seventy-five percent (75%).

Cost Report Period	Rate Period	% Occupancy
SFY 2022	SFY 2023	60%
SFY 2023	SFY 2024	65%
SFY 2024	SFY 2025	70%
SFY 2025	SFY 2026	70%
SFY 2026	SFY 2027	75%
& after	& after	

Resident days at the minimum occupancy level are calculated as:
 Total Licensed Beds x Number of Days in the Period x Minimum Occupancy Percentage.

(3) Return on equity.

(4) The return on equity portion of the fair market rental payment will be calculated by taking the current asset value (CAV) of a facility

less the ending loan balance on any loans used to finance fixed assets or major movable equipment, times the sum of the average Moody's Seasoned Baa Corporate Bond Yield for the month of June in the applicable cost reporting period plus one and a half percent (1.5%) as a risk premium. For purposes of calculating return on equity and determining allowable interest expense, allowable debt cannot exceed the facilities current asset value. The maximum rate used for calculating return on equity will be ten percent (10%).

(B) The CAV of a facility is calculated by multiplying the number of beds in a facility by the per bed valuation (PBV) less an aging index of one percent (1%) for each year of age, not to exceed a fifty percent (50%) reduction in PBV. A facility will be considered new the cost reporting period in which the facility is licensed. A facility will be considered one (1) year old the following cost reporting period. The CAV of a facility will be recalculated and an appropriate adjustment to the per diem will be made when additional beds are placed in operation.

(C) Beginning with the CY 2023 rate year and based on the base PBV for the SFY cost reporting period, the PBV methodology shall differentially apply PBV amounts according to the class of resident room where a licensed bed is located.

Class A Resident Room	
Criteria for Class A Room	PBV Applicable to Each Licensed Bed in a Class A Room

<p>A private, single occupancy resident bedroom. Maximum of one licensed bed per room.</p> <p>Each Class A private room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private resident room.</p> <p>A Class A room must meet minimum space and other standards for private rooms and attached private bathrooms as set in department regulations for a licensed SNF.</p>	<p>Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is \$196,977.</p> <p>Updated annually as Base PBV is updated for increases in the construction index.</p>
<p>Class B Resident Room</p>	
<p>Criteria for Class B Room</p>	<p>PBV Applicable to Each Licensed Bed in a Class B Room</p>

<p>A semi-private, double occupancy resident bedroom. Maximum of two licensed beds per Class B room.</p> <p>Each Class B room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private or semi-private resident room.</p> <p>A Class B room must meet minimum space and other standards for semi-private rooms and attached private bathrooms as set in department regulations for a licensed SNF.</p>	<p>Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is \$140,594.</p> <p>Updated annually as Base PBV is updated for increases in the construction index.</p>
<p>Class C Resident Room</p>	
<p>Criteria for Class C Room</p>	<p>PBV Applicable to Each Licensed Bed in a Class C Room</p>
<p>A Class C room is any resident room that does not meet the criteria for a Class A room or Class B room.</p> <p>Maximum of two licensed beds per Class C room.</p> <p>For example, a Class C room includes any private or semi-private room lacking an attached private</p>	<p>Fixed at the Per Bed Value in effect on June 30, 2022, with no annual update thereafter for the construction index.</p>

<p>bathroom or where the occupants otherwise must rely on a communal bathroom(s) for toileting.</p>	
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(D) The PBV will be adjusted annually thereafter to reflect changes in construction costs as indicated per the Core Logic Marshall & Swift Valuation Service. A percentage increase will be calculated by dividing the difference between the comparative cost multipliers construction index for Little Rock, Arkansas, for the quarter ending January of the cost reporting period and January of the previous year. The annual adjustment percentage will be the lesser of the percentage as calculated above for building classes: 1) masonry bearing walls, 2) wood frame, or five percent (5%).

(E) Every five (5) years, the Division of Medical Services shall analyze and compare the annual updates made using the construction cost index and the actual total cost, including physical plant, fixed equipment, land acquisitions, and land improvements, of new SNF construction in Arkansas during the same period. The division shall rebase the base PBV if actual construction costs increased more than estimated by the construction index.

(4) Facility rental factor. A facility rental factor will be paid for each facility. The rental factor is calculated by multiplying the CAV of the facility by two and a half percent (2.5%).

(5) Cost of ownership. The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums, including professional liability and property, as identified on the facility's cost report.

The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in 20 CAR § 579-302(10)(I).

(6) Minor equipment purchases. The cost of purchases of minor equipment is not covered in the fair market rental payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of less than two thousand five hundred dollars (\$2,500). Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used, i.e., direct care cost component or indirect, administrative, and operating component.

(7) Renovations.

(A) The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10%) of the facility's current per bed value for the beds renovated or five percent (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

(B) Adjustments to the aging index will be rounded to a whole percentage. Percentages greater than or equal to one-half percent (.5%) will be

rounded up. Percentages less than one-half percent (.5%) will be rounded down. A facility wishing to do major renovation to their facility must submit a plan for renovation to the department for review and approval to facilitate an adjustment to the provider's aging index. The duration of the renovation plan cannot exceed a three-year period. The plan shall include a detailed description of the renovation to be done along with the cost of the renovation. The department will determine if the proposed renovation meets the requirements for major renovation.

(C) The department will approve or disapprove the renovation project within thirty (30) days of receipt. The provider will then submit a detailed description of the actual work performed and a statement of the actual cost of the renovation upon completion of the project. Renovations that were not completed in compliance with the plan for renovation will not be considered. The department will notify the provider of the adjustment to the facility aging index as a result of the major renovation. Under no circumstances will the aging index be reduced to less than zero (0).

(8) Aging index. Age of provider beds for purposes of calculating the aging index were taken from surveys provided by the Arkansas Health Care Association as prepared by providers. The provider is responsible for the accuracy of the information provided. The provider may at any time be required to provide records validating this information. The aging index is subject to adjustment based upon review or audit;

(d) Quality assurance fee. Acts 2001, No. 635, established the levy of a quality assurance fee on nursing facilities. The reimbursement rate paid nursing facilities will include a quality assurance fee component. The quality assurance fee component will be reimbursed at the amount established as the multiplier as defined in Acts 2001, No. 635, for the date of service billed; and

(e) Emergency generators.

(1) Acts 2001, No. 1602, requires nursing facilities to own and maintain emergency generators. This establishes an add-on payment for installing emergency generators applicable only to first time emergency generators installed in

order to comply with Acts 2001, No. 1602. Facilities that do not meet the requirement of existing facility as defined in Acts 2001, No. 1602, will not receive any add-on payment in addition to the facility's fair market rental payment. Add-on payments shall be made only for the periods that depreciation or lease expense for the cost of first time generator installations is allowable.

(2) Facilities will be required to submit copies of invoices indicating generator cost and a copy of the financing arrangement, if any, for the emergency generator installation or a copy of the generator operating lease, if any. Facilities that fail to provide this information by December 1, 2002, will not be paid the add-on for thirty (30) days past the date of submission. Should the financing arrangement on the emergency generator change during the add-on period, the facility must provide revised financing information that will be used to calculate the add-on for the following calendar year.

(3) Facilities will be paid an add-on to their per diems for installing emergency generators. The add-on payment will begin January 1, 2003, and will be adjusted each January 1 for the period the add-on is applicable. Using cost information supplied by the facility, the add-on will be calculated by dividing the sum of projected yearly depreciation and projected yearly interest expense or projected yearly lease expense by the greater of the actual resident days from the previous cost reporting period or resident days calculated at the minimum occupancy levels identified in subdivision (1)(A)(iii)(c) of this section, fair market rental.

(4) Depreciation will be calculated using the straight-line method assuming a useful life of ten (10) years. Interest expense will be allowable and included in the add-on for emergency generators for a maximum period of five (5) years. Interest expense and the associated debt instrument reimbursed under this provision will not be included in the fair market rental payment or any other component of the rate. Lease expense on emergency generator systems will only be allowable for a maximum period of ten (10) years.

(5) Change of ownership does not affect add-on payments. Facilities that change ownership while receiving a generator add-on payment will

continue to receive the add-on for the remainder of the allowable period identified above using the original owner's projected expense.

(B) Facility payments — Interim rates.

(i) An interim rate will be established at the beginning of each state fiscal year for each facility. The interim rate will be established by applying the inflation index to the actual per diem rate from the previous rate period. For the period January 12, 2001, to June 30, 2001, an actual rate will be calculated from cost reports submitted for the period July 1, 1999, to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated. The interim rate is necessary to allow time for providers to complete cost reports and allow the department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

(ii) The following formula will be used to calculate the weighted per diem rate.

$\{(Actual\ per\ diem\ rate \times 12) - (Interim\ rate \times months\ used)\} / Months\ remaining.$

(C) Provisional rate.

(i) A provisional rate will be paid to a provider who:

(a) Constructs a new facility; or

(b) Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

(ii) The provisional rate will be established as follows:

(a) The direct care per diem rate will be established at the inflation adjusted ceiling for that rate period;

(b) The indirect, administrative, and operating per diem will be the class rate as established for that rate period; and

(c) The fair market rental payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent (50%) when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percentage of occupancy can do so by supplying projected occupancy figures to the department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The division will adjust the facility's provisional rate prospectively based on the information provided.

(iii) Facilities who are placed on a provisional rate as detailed above must submit a six-month cost report as required in 20 CAR § 579-106. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner:

(a) The provider's direct care per diem rate will be calculated from the six-month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two (2) rate periods, the applicable rate period will be considered the one that contains the majority of the days included in the six-month report;

(b) The indirect, administrative, and operating per diem will continue to be the class rate as established in the provisional rate; and

(c) The amount identified as the sum of the components used in the original calculation, as adjusted for actual cost data if applicable, for the fair market rental payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not

previously participated or fifty percent (50%) occupancy for new facilities. After the initial six-month reporting period the fair market rental payment will be calculated using a minimum occupancy factor as required in subdivision (1)(A)(iii)(c) of this section, for both new facilities and facilities that were not previously enrolled.

(iv) If either the provisional rate or the actual rate calculated from the six-month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

(D) Rates for facilities that change ownership. Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be reimbursed the previous operator's rate as of the date of the change of ownership. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in subdivision (1)(F) of this section.

(E) Terminating facilities. Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility.

(F) Inflation index. For all inflation adjustments, unless stated otherwise in the specific area of the plan, the department will use the Skilled Nursing Facility Market Basket Index as published by the Centers for Medicare and Medicaid Services. The department will use the four quarter moving average percent change identified for the final quarter of the rate period.

(G) Adjustments to provider cost reports. Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason, a retroactive adjustment will be made for all resident days paid back to the beginning of the rate

period. Adjustments to a provider's per diem resulting from any source other than an inquiry for additional information as a result of a desk review for which provided within required deadlines will only affect the per diem for that particular provider. Cost component ceilings for applicable cost components and the floor established for direct care will not be adjusted under these circumstances.

(H) Cost components. For rate setting, facility allowable costs from desk-reviewed facility cost reports for an annual period ending June 30, will be identified and grouped as: direct care; indirect, administrative, and operating; property costs (identified for informational purposes, the reimbursement rate for property costs will be determined by the fair market rental method as outlined above in subdivision (1)(A)(iii)(c) of this section); and quality assurance fee.

(i) Direct care expenses. The following expenses are classified as direct care:

- (a)* Salaries — Aides;
- (b)* Salaries — Medication assistants;
- (c)* Salaries — LPNs;
- (d)* Salaries — RNs;
- (e)* Salaries — Occupational therapists;
- (f)* Salaries — Physical therapists;
- (g)* Salaries — Speech therapists;
- (h)* Salaries — Other therapists;
- (i)* Salaries — Rehabilitation nurse aide;
- (j)* Salaries — Assistant Director of Nursing;
- (k)* Salaries — Director of Nursing;
- (l)* FICA — Direct care;
- (m)* Group health — Direct care;
- (n)* Pensions — Direct care;
- (o)* Unemployment taxes — Direct care;
- (p)* Uniform allowances — Direct care;
- (q)* Workers' compensation — Direct care;

- (r)* Other fringe benefits — Direct care;
- (s)* Contract — Aides;
- (t)* Contract — Medication assistants;
- (u)* Contract — LPNs;
- (v)* Contract — RNs;
- (w)* Training — Direct care;
- (x)* Drugs, over-the-counter;
- (y)* Oxygen;
- (z)* Medical supplies — Direct care;
- (aa)* Contract — Occupational therapists;
- (bb)* Contract — Physical therapists;
- (cc)* Contract — Speech therapists;
- (dd)* Contract — Other therapists;
- (ee)* Therapy supplies;
- (ff)* Consultant fees — Nursing;
- (gg)* Raw food;
- (hh)* Food supplements; and
- (ii)* Incontinence supplies.

(ii) Indirect, administrative, and operating. The following expenses are classified as indirect, administrative, and operating:

- (a)* Salaries — Administrator;
- (b)* Salaries — Assistant administrator;
- (c)* Salaries — Dietary;
- (d)* Salaries — Housekeeping;
- (e)* Salaries — Laundry;
- (f)* Salaries — Maintenance;
- (g)* Salaries — Medical records;
- (h)* Salaries — Other administrative;
- (i)* Salaries — Owner or owner/administrator;
- (j)* Salaries — Activities;

- (k)* Salaries — Pharmacy;
- (l)* Salaries — Social services;
- (m)* FICA — Indirect, administrative, and operating;
- (n)* Group health — Indirect, administrative, and operating;
- (o)* Pensions — Indirect, administrative, and operating;
- (p)* Unemployment taxes — Indirect, administrative, and
operating;
- (q)* Uniform allowance — Indirect, administrative, and operating;
- (r)* Workers' compensation — Indirect, administrative, and
operating;
- (s)* Other fringe benefits — Indirect, administrative, and
operating;
- (t)* Barber and beauty expense — Allowable;
- (u)* Consultant fees — Activities;
- (v)* Consultant fees — Medical director;
- (w)* Consultant fees — Pharmacy;
- (x)* Consultant fees — Social worker;
- (y)* Consultant fees — Therapists;
- (z)* Medical transportation;
- (aa)* Patient activities;
- (bb)* Supplies — Care related;
- (cc)* Other care-related costs;
- (dd)* Contract — Dietary;
- (ee)* Contract — Housekeeping;
- (ff)* Contract — Laundry;
- (gg)* Contract — Maintenance;
- (hh)* Consultant fees — Dietician;
- (ii)* Consultant fees — Medical records;
- (jj)* Accounting fees;
- (kk)* Advertising for labor/supplies;

- (ll)* Amortization expense — Noncapital;
 - (mm)* Bank service charges;
 - (nn)* Board of directors fees;
 - (oo)* Data processing fees;
 - (pp)* Dietary supplies;
 - (qq)* Depreciation expense;
 - (rr)* Dues;
 - (ss)* Educational seminars and training;
 - (tt)* Housekeeping supplies;
 - (uu)* Interest expense — Noncapital;
 - (vv)* Laundry supplies;
 - (ww)* Legal fees;
 - (xx)* Linen and laundry alternatives;
 - (yy)* Miscellaneous;
 - (zz)* Management fees and home costs;
 - (aaa)* Office supplies and subscriptions;
 - (bbb)* Postage;
 - (ccc)* Repairs and maintenance;
 - (ddd)* Taxes – Other;
 - (eee)* Telephone and communications;
 - (fff)* Travel;
 - (ggg)* Utilities;
 - (hhh)* Criminal backgrounds check;
 - (iii)* Vehicle depreciation; and
 - (jjj)* Vehicle interest.
- (iii) Property. The following expenses are classified as property:
- (a)* Insurance — Professional liability;
 - (b)* Amortization expense — Capital;
 - (c)* Depreciation;
 - (d)* Interest expense — Capital;

- (e)* Property insurance;
- (f)* Property taxes;
- (g)* Rent – Building; and
- (h)* Rent – Furniture and equipment.

(iv) Quality assurance fee.

(I) Nonstate public nursing facility adjustment. Effective January 1, 2004, the nonstate public nursing facility adjustment is eliminated.

(J) Home style facilities.

(i) Fair market rental payment.

(a) Minimum occupancy rules (as defined in subdivision (1)(A)(iii)(c) of this section) for calculating the facility fair market rental payment will be calculated and applied separately for beds certified as home style. All other policy described in this cost manual regarding the calculation of a facility's fair market rental payment is applicable to home style facility beds.

(b) All costs associated with renovating or constructing beds for initial certification as home style shall not be considered a renovation as detailed in subdivision (1)(A)(iii)(c) of this section. Thereafter, home style beds are eligible for renovation adjustment as detailed in the cost manual.

(c) A nursing facility participating in this program may certify less than one hundred percent (100%) of its beds as home style facility beds. A facility may have a combination of traditional style nursing facility beds and home style facility beds within a single licensed facility.

(ii) Cost reporting.

(a) A facility or any part thereof certified by the Office of Long-Term Care as home style shall prepare and submit a financial statistical report/cost report. The cost report for home style beds will be identified as such by including the words "home style" at the end of the facility name wherever used. The cost report must be prepared in accordance with all reimbursement rules and reporting requirements detailed in the Manual of Cost Reimbursement Rules. Combination facilities will be required to complete a separate cost report for both the traditional beds and beds

certified as home style facility beds. Whenever possible, costs that can be directly identified to either the traditional or home style beds must be included on the appropriate cost report. The department recognizes that certain costs cannot be directly identified and benefit both reporting entities. These shared costs must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the current asset value (CAV). All other shared cost must be allocated based on resident days. The cost report for the home style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and home style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and home style.

(b) The cost report for home style beds will be used for the purpose of establishing a per diem rate for the facility's home style beds.

(c) Full year cost reports for facilities certified entirely as home style facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative, and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative, and operating, and will be included in the overall rate setting process as well.

(iii) Staffing. Certified nurse assistants (CNAs) utilized in staffing home style beds are designated as universal workers within the home style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping, and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNAs are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

(iv) Rate setting. With the exceptions detailed above, the per diem rate for beds certified as home style beds will be established in the same manner as

traditional beds;

(2) Intermediate care facilities for individuals with intellectual disabilities.

(A) Sixteen-bed and over — State-operated facilities.

(i) Effective January 1, 1994, the method of reimbursement for intermediate care facilities for individuals with intellectual disabilities (ICF/IID) state-operated facilities certified as having more than fifteen (15) beds will be based on actual cost with provisions for retrospective adjustment semiannually to ensure reimbursement of actual allowable, reasonable costs. Each facility will have an interim per diem rate established based on the most recent semiannual cost report. This interim per diem rate will be adjusted retrospectively as a result of actual costs for that semiannual cost reporting period. Rates established for this facility type shall be changed due to adjustments to the semiannual cost reports resulting from provider corrections, desk reviews, or audits and will be retrospectively adjusted to the first day of the applicable cost report period. The reimbursement methodology for this type facility will be adjusted by submission of a state plan amendment as warranted.

(ii) Provider fee. Acts 2009, No. 433, established the levy of a provider fee on intermediate care facilities for individuals with developmental disabilities. The reimbursement rate paid sixteen-bed and over state-operated facilities will include a provider fee component. The provider fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

(B) Sixteen-bed and over — Private facilities.

(i) Reimbursement methodology. Effective with dates of service on or after January 1, 1999, ICF/IID sixteen-bed and over facilities will be paid a prospective rate based on a combination of actual allowable cost for direct care and care-related costs and a class rate up to a ceiling for administrative and operating costs. Effective the beginning of each state fiscal year, rates will be rebased or adjusted for inflation. The department will in its sole discretion determine whether to rebase the rate or apply an inflationary adjustment.

(ii) Cost categories.

(a) For rate setting, facility allowable costs from desk-reviewed facility cost reports for an annual period determined by the department, will be identified and grouped as direct care and care-related or administrative and operating. Direct care and care-related include those expenses the facility incurs in providing care directly to the resident. Because these costs most directly affect the quality of care given a resident, the methodology includes as a component the actual allowable cost incurred for direct care and care-related costs.

(b) Administrative and operating constitute the remainder of facility costs. Costs associated with administrative and operating are more directly controllable by the facility. The methodology includes as a component a class rate up to a ceiling to cover the costs for administrative and operating.

(c) For rates effective January 1, 1999, desk-reviewed facility cost reports for the period 1/1/97 through 6/30/97 and 7/1/97 through 12/31/97 were combined to establish the base year rates. Rebasing and cost reporting period for rebasing will be at the discretion of the department. Should the department decide to rebase, the most currently available desk-reviewed cost reports will be used.

(iii) Rate setting. Rates will be established in the following manner: an average per diem cost for administrative and operating will be calculated for the facility class. This will be accomplished by determining per diem cost for administrative and operating for each facility by dividing the actual allowable cost for each facility by their total resident days, adding the individual facility per diem costs and dividing by the number of facilities within the facility class. A ceiling for administrative and operating will be set at one hundred five percent (105%) of the average. A facility will be paid at the lesser of the ceiling or their actual per diem cost plus ten percent (10%) of the amount calculated as one hundred five percent (105%) of the average. A per diem cost will be calculated for each facility for direct care and care-related costs. The per diem cost will be calculated by dividing the actual allowable cost for each facility by their total resident days. A facility's per diem cost for direct care and care-related cost and administrative and operating cost will be combined to get a facility's total per diem. Once the total per diem by facility has been established, these rates will be adjusted for

inflation from the base year to the rate year. In years that the rates are not rebased, existing rates will be adjusted for projected inflation. The department will use the HCFA Input Price Index (market basket) – Nursing Facilities published quarterly for determining appropriate inflation rates. Facility rates will be rebased periodically at the department’s discretion.

(iv) Provider fee. Acts 2009, No. 433, established the levy of a provider fee on intermediate care facilities for individuals with developmental disabilities. The reimbursement rate paid sixteen-bed and over private facilities will include a provider fee component. The provider fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

(v) Enhanced care add-on.

(a) The department recognizes that the current rate structure limits the providers’ ability to invest additional moneys for the purpose of improving the quality of care. Additionally, the recent increase in the minimum wage (an unfunded federal mandate) will make it difficult for providers to maintain current standards much less improve the quality of care. Therefore, the department will implement an enhanced care add-on in the amount of ten dollars and fifty-four cents (\$10.54) per day. This enhanced payment will provide additional funds for wage adjustments in the base salaries for new hires and incumbent salaries to address the increase of the federal minimum wage in July, 2009. This will also directly increase benefits related to these salary increases such as FICA, LTD, life insurance, retirement, etc. This add-on will also provide funding for additional initiatives to improve the quality of care.

(b) The following list of items identifies these additional initiatives:

(1) Enhanced staff resources for staff development, nursing, psychological, and other professional personnel;

(2) Enhanced maintenance cost due to the aging of the facilities;

(3) Enhanced direct care staff and increase in number of staff to meet increased needs of children with autism and other behavior needs in order

to maintain a quality standard of care and ensure the health and safety of all children being served;

(4) Enhanced technology (computers, teleconferencing, electronic files, electronic time keeping, etc.);

(5) Software for client programming, client data bases, billing etc.;

(6) Security cameras/lighting; and

(7) Other items deemed appropriate in providing enhanced care.

(c) The enhanced care add-on is paid in addition to the rate components identified in subdivision (2)(B)(i) and (ii) of this section.

(vi) Rate justification. Modeling of this methodology produced estimates that each facility identified as efficient and economic (providers operating at or below the median of arrayed nondirect care costs) would receive payment equaling one hundred percent (100%) (plus or minus five percent (5%)) of that facility's actual allowable cost. Cost coverage in the aggregate is equal to or less than one hundred percent (100%) for ICF/IID facilities.

(C) Under sixteen beds.

(i) Small ICF/IID facilities certified as having fifteen (15) beds or fewer will be reimbursed on a prospective uniform class rate system. An inflationary adjustment, determined by the division to be reasonable and adequate, will be applied to the existing rates and will be implemented by state plan amendment as warranted by analysis of cost report data. Cost reports will be submitted annually for the preceding calendar year (January 1 – December 31) and will be reviewed prior to establishing new rates. The division has established the per diem rate of one hundred ninety-five dollars and forty-three cents (\$195.43) for dates of service beginning July 4, 2013.

(ii) Provider fee.

(a) Acts 2009, No. 433, established the levy of a provider fee on intermediate care facilities for individuals with developmental disabilities. The reimbursement rate paid under sixteen (16) beds facilities will include a provider fee

component. The provider fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

(b) The provider fee component is paid in addition to the rate identified in subdivision (2)(C)(i) of this section.

(iii) Enhanced care add-on.

(a) The department recognizes that the current class rate structure limits the providers' ability to invest additional moneys for the purpose of improving the quality of care. Additionally, the recent increase in the minimum wage (an unfunded federal mandate) will make it difficult for providers to maintain current standards much less improve the quality of care. Therefore, the department will implement an enhanced care add-on in the amount of seven dollars and two cents (\$7.02) per day. This enhanced payment will provide additional funds for wage adjustments in the base salaries for new hires and incumbent salaries to address the increase of the federal minimum wage in July, 2009. This will also directly increase benefits related to these salary increases such as FICA, LTD, life insurance, retirement, etc. This add-on will also provide funding for additional initiatives to improve the quality of care.

(b) The following list of items identifies these additional initiatives:

(1) Enhanced staff resources for staff development, nursing, psychological, and other professional personnel;

(2) Enhanced therapy services to meet increasing behavior needs of the aging population being served;

(3) Enhanced maintenance and housekeeping staff;

(4) Enhanced direct care staff;

(5) Generators;

(6) Enhanced technology (computers, teleconferencing, electronic files, electronic time keeping, etc.);

(7) Software for client programming, client data bases, billing etc.;

(8) Security cameras/lighting; and

(9) Other items deemed appropriate in providing enhanced care.

(c) The enhanced care add-on is paid in addition to the rate components identified in subdivision (2)(C)(i) and (ii) of this section.

(iv) Overpayments/underpayments. Overpayments/underpayments resulting from 20 CAR § 579-112 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments; and

(3) SNF and ICF — Special class — Arkansas Health Center Nursing Facility.

(A) Reimbursement methodology. The Arkansas Health Center Nursing Facility will be reimbursed on an actual cost reimbursement system with provisions for retrospective adjustments to ensure reimbursement of actual allowable and reasonable costs. The facility will have an interim per diem rate established based on the most recent semiannual cost report. This interim per diem rate will be adjusted retrospectively as a result of actual costs for that semiannual cost reporting period. The per diem will be calculated by dividing actual allowable cost by resident days for the cost reporting period. The per diem rate shall be changed as a result of adjustments to the semiannual cost reports resulting from provider corrections, desk reviews, or audits, and will be retrospectively adjusted to the first day of the applicable cost report period.

(B) Overpayments/underpayments. Overpayments/underpayments resulting from 20 CAR § 579-112 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-206. Mandatory changes.

(a)(1) The Department of Human Services acknowledges that state laws passed by the General Assembly and administrative rules promulgated by the Division of Medical Services occasionally require the state's long-term care facilities to incur costs which were not incurred prior to the adoption of the law or rule.

(2) The department will assess the impact of newly required costs and, when warranted, seek additional reimbursement through the state and federal executive and legislative agencies.

(3) The division will implement any available additional reimbursement, including appropriate retroactive payments, within the quarter following all necessary approvals, appropriation, and funding.

(b)(1) The department will inform state and federal agencies proposing new nursing facility mandates of the projected costs, if any, of such mandates.

(2) If a proposed mandate would substantially increase costs without attendant state and federal funding, the department will object to implementing the mandate without corresponding state and federal funding.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Subpart 3. Allowable Costs

20 CAR § 579-301. General information.

(a) This subpart sets forth principles for determining the allowable costs for the facilities which:

(1) Meet the definition of a nursing facility (NF) under 42 C.F.R. pt. 483, subpt. B, if licensed and certified as an NF;

(2) Meet the definition of an intermediate care facility for individuals with intellectual disabilities (ICF/IID) under 42 C.F.R. pt. 483, subpt. I, if licensed and certified as an ICF/IID;

(3) Meet certification requirements to participate in the Medicaid program as an NF or ICF/IID; and

(4) Are primarily engaged in providing to residents:

(A) Skilled nursing care and related services for residents who require medical or nursing care;

(B) Rehabilitation services for the rehabilitation of injured, disabled, or

sick persons; or

(C) On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services, above the level of room and board, which can be made available to them only through institutional facilities.

(b)(1) The Medicare Provider Reimbursement Manual (HCFA Publication 15-1) and the federal regulations appropriate to the recognition of costs for facilities under the Medicare program are a supplement to this subpart.

(2) A facility shall use the Medicare Provider Reimbursement Manual and federal regulations for the sole purpose of determining the allowability of a specific cost not determinable by reference to this manual.

(3) A facility may not use the Medicare Provider Reimbursement Manual or federal regulations for a cost that is determined to be unallowable in this subpart.

(4) A facility may not use the Medicare Provider Reimbursement Manual or federal regulations to alter the treatment of a cost provided for in this subpart.

(c)(1) Generally accepted accounting principles (GAAP) as interpreted in the opinions of the American Institute of Certified Public Accountants and in the statements by the Financial Accounting Standards Board are a supplement to this subpart.

(2) A facility shall use GAAP for cost issues which are not specifically addressed in this subpart, the Medicare Provider Reimbursement Manual, or federal regulations.

(3) A facility may not use GAAP for a cost that is determined to be unallowable in either this subpart, the Medicare Provider Reimbursement Manual, or federal regulations.

(4) A facility may not use GAAP to alter the treatment of a cost provided for in this subpart, the Medicare Provider Reimbursement Manual, or federal regulations.

(d)(1) Allowable costs must be reported on a full accrual basis of accounting.

(2) If a facility maintains its internal records on a basis other than the accrual method, it will be necessary to convert to the accrual basis for cost reporting purposes.

(3) This does not apply to state-owned facilities.

(e)(1) The Department of Human Services defines allowable and unallowable costs

to identify expenses which are reasonable and necessary to provide recipient care to Medicaid recipients by an economical and efficient provider.

(2) The primary objective of the cost reporting process is to provide adequate data for the determination of fair and reasonable reimbursement rates to providers.

(3) To achieve that objective, the Department of Human Services compiles a rate base consisting, if possible, only of allowable cost information.

(4) If the Department of Human Services classifies a particular type of expense as unallowable for purposes of compiling a rate base, it does not mean that individual providers may not make expenditures of this type.

(f) **Definitions.** The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

(1)(A) "Allowable costs" means those expenses that are reasonable and necessary in the normal conduct of operations to provide recipient care in a facility.

(B)(i) "Reasonable" means the amount expended.

(ii) The test of reasonableness is that the amount expended does not exceed the cost which would be incurred by a prudent business operator seeking to contain costs.

(C) "Necessary costs" means those costs essential:

(i) To operate a long-term care facility and deliver long-term care in conformity with applicable federal, state, and local laws, rules, ordinances, and codes; and

(ii) To attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.

(D) "Normal conduct of operations" relating to recipient care means otherwise allowable costs that include, but are not limited to, the following:

(i)(a) Expenses for facilities, materials, supplies, or services used by a facility solely for providing long-term recipient care.

(b) Whenever otherwise allowable costs are attributable partially to personal or other business interests and partially to facility recipient care, the latter portion may be allowed on a pro rata basis if the basis for allocation of expense for

recipient care purposes is well-documented.

(c) This documentation includes the allocation methodology and appropriate logs necessary to support amount attributed to recipient care; and

(ii)(a) Allowable costs which result from arms-length transactions involving unrelated parties.

(b) In transactions involving related organizations, the allowable cost to the facility is the cost to the related party.

(c) Allowable costs in this regard are limited to the lesser of the actual purchase price to the related party, or usual and customary charges for comparable goods or services.

(E) Allowable costs must be reported net of any applicable returns, allowances, discounts, and refunds;

(2) "Arms-length transaction" means a voluntary transaction between a knowledgeable and willing buyer unrelated to the seller, with each acting for his or her own independent self-interest.

(3)(A)(i) "Costs of related organizations". Costs for services or supplies furnished to the facility by related organizations are allowable at the cost to the related party to the extent that they are reasonable and necessary in the normal conduct of operations relating to recipient care in a facility and do not exceed those costs incurred by a prudent buyer.

(ii) Providers should treat the cost incurred by the related party as if they were incurred by the provider itself.

(iii) Providers must supply a detailed income statement from the related party entity so the proper cost report classification can be determined.

(iv)(a) If the cost to the related party would be classified as a direct care cost by the nursing facility, then the related cost must be claimed on a direct care line on the cost report.

(b) If the cost to related party would be classified as an indirect, administrative, and operating cost by the nursing facility, then the related party cost must be claimed on an indirect, administrative, and operating cost report line.

(c) If the cost to related party would be classified as a property cost by the nursing facility, then the related party cost must be claimed on a property cost report line.

(v) Expenses for transactions with related organizations should not exceed expenses for like items in arms' length transactions with other nonrelated organizations.

(B) "Related organization". A related organization, which includes individuals, partnerships, corporations, etc., is one where the provider is associated or affiliated with, has common ownership, control, or common board members, or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(C) "Common ownership". Common ownership exists when an entity, individual, or individuals possess five percent (5%) or more ownership or equity in the provider and the institution or organization serving the provider.

(D) "Control". Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(E)(i) "Immediate family relationship". Immediate family members are related parties.

(ii) "Immediate family members" include:

- (a) Husband/wife;
- (b) Natural parent, child, or sibling;
- (c) Adoptive child and adoptive parent;
- (d) Step-parent;
- (e) Step-child;
- (f) Step-sibling;
- (g) Father-in-law;
- (h) Mother-in-law;
- (i) Brother-in-law;
- (j) Sister-in-law;

- (k)* Son-in-law;
- (l)* Daughter-in-law;
- (m)* Grandparent; and
- (n)* Grandchild.

(F)(i) "Exception". An exception to the general rule applicable to related organizations exists where large quantities of goods and services are furnished to the general public by the related organization and sales to the facility represent no more than five percent (5%) of the gross receipts of the related organization.

(ii) The facility must demonstrate to the satisfaction of the Department of Human Services that all of the following criteria are met:

(a) The supplying organization is a bona fide separate organization;

(b) A substantial part of the supplying organization's business activity with the facility is transacted with other organizations not related to the facility and the supplier by common ownership and there is an open, competitive market for the type of services, supplies, or facilities furnished by the organization;

(c) The services, supplies, or facilities are those commonly obtained by facilities from other organizations and are a necessary element of resident care; and

(d) The charge to the facility is no more than the charge for such services, supplies, or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies, or facilities.

(G)(i) The facility must furnish to the Department of Human Services adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies, services, or facilities furnished to the facility.

(ii) Such documentation must include an identification of the organization's total costs, and the basis for allocating direct and indirect costs to the facility and to other entities served.

(H)(i) Limitations on cost for related party transactions will not apply to the sale of one (1) or more nursing facilities by a person to that person's child or children for money equal to the fair market value of the facility or facilities.

(ii) All other rules relating to the sale of a facility will apply;

(4) "Prudent buyer concept" means allowable costs may not exceed the cost that a prudent buyer would pay in the open market to obtain products or services; and

(5)(A) "Unallowable costs" means those expenses that are not reasonable or necessary for the provision of recipient care in a facility, according to the criteria as specified in subdivision (f)(1) of this section.

(B) Unallowable costs are not included in the rate base used for determining reimbursement rates.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-302. List of allowable costs.

The following list of allowable costs is not all inclusive but serves as a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost. As discussed further in 20 CAR § 579-304, certain income items will reduce allowable costs and be offset against the appropriate line items for salaries and wages or other service expenses. Except where specific exceptions are noted, the allowability of all costs is subject to the amounts being reasonable and to the other general principles specified in 20 CAR § 579-301:

(1)(A) Compensation of facility employees. This includes compensation for only those employees who provide services directly to the recipients or staff of individual facilities in the normal conduct of operations relating to recipient care: certified nurse aides; nurse aides in training; medication assistants; licensed practical nurses; graduate practical nurses; registered nurses; graduate nurses; other salaried direct care staff; occupational therapists; physical therapists; speech therapists; other therapists; activities personnel; Assistant Director of Nursing; Director of Nursing; pharmacy personnel; social services personnel; administrator; assistant administrator; food service

personnel; housekeeping, laundry, and maintenance staff; medical records personnel; other administrative staff; accounting staff; and data processing personnel.

Compensation for employees related to the owners, partners, or stockholders of the facility are subject to the limitation established in this section.

(B) Compensation includes:

(i) Wages and salaries;

(ii) The employer's portion of payroll taxes and other mandatory insurance payments. Federal Insurance Contributions Act (FICA or Social Security), Unemployment Compensation Insurance, Workers' Compensation Insurance premiums and other payments mandated by workers' compensation laws, including self-insurance payments, and payments direct to hospitals or physicians for treating minor injuries.

(iii) Employee benefits. Employer-paid health, life, accident, and disability insurance for employees; uniform allowance and meals provided to employees as part of an employment contract; contributions to an employee retirement fund; and deferred compensation. The allowable portion of deferred compensation is limited to the dollar amount that an employer contributes during a cost reporting period. The expenses must:

(a) Represent a clearly enumerated liability of the employer to individual employees;

(b) Be incurred as a benefit to employees who provide services to the recipients or staff of an individual facility; and

(c) Be offered to all full-time nonprobationary employees on an equal basis in accordance with an employee benefit policy established in writing.

Employers may offer different fringe benefits to different employee classes. Fringe benefits offered to only certain employees within the same employee class of the facility are considered discriminatory fringe benefits and are not allowable. Employee classes must be reasonably related to employee job duties and may not distinguish between persons similarly situated. Reasonable uniform allowances, and life insurance policies on key personnel as required to obtain a loan from an unrelated party, are exempt from this rule;

(2)(A) Compensation of owners, partners, or stockholders. Note. These provisions do not apply to corporations whose stock is publicly traded. Compensation will be included as an allowable cost to the extent that it represents reasonable remuneration for managerial, professional, and administrative 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 supervision of the overall institution.

(B) To be included as allowable cost, the compensation shall not exceed one hundred fifty percent (150%) of the median wage (excluding nonwage compensation) for comparable positions in facilities that do not have owner operators. Cost reports from the previous reporting period will be used for setting the ceiling. The HCFA Market Basket projection of inflation will be used to adjust ceilings calculated from the cost reporting period to the rate setting period. Three (3) peer groups will be established for this purpose:

(i) Less than seventy-five (75) licensed beds;

(ii) Seventy-five (75) to one hundred forty-nine (149) licensed beds;

and

(iii) One hundred fifty (150) licensed beds or more. This ceiling is established based on a forty-hour workweek. Owner administrators working less than forty (40) hours per week must adjust allowable compensation accordingly;

(3) Cost of contracted services. This means costs of services defined in 20 CAR § 579-301(f)(1) procured by contract;

(4) Management fees paid to unrelated parties. The Department of Human Services considers management fees paid to unrelated parties as allowable only to the extent that such fees are reasonable and are in accordance with the other general requirements of 20 CAR § 579-301;

(5)(A) Management fees paid to related party organizations and other home office overhead expenses. These fees and expenses paid to a related organization may not exceed the actual cost of materials, supplies, or services provided to an individual

facility. A facility that is owned, operated, or controlled by another individual or individuals or organization or organizations may report the allowable portion of costs for materials, supplies, and services provided to that facility. The allowable portion of such costs to a given facility is limited to those expenses that can be attributed to the individual establishment.

(B) In multi-facility organizations where the clear separation of costs to individual facilities is not always possible, the allowable portion of actual costs for materials, supplies, and services may be allocated to individual facilities on a pro rata basis. The required allocation method for these costs is a bed day's basis. Providers who wish to use an alternative allocation methodology may do so by obtaining prior written approval from the Secretary of the Department of Human Services, or the secretary's designee, before implementation. Once a provider has chosen an alternative allocation method, and it has been approved, it must be consistently used in preparing subsequent cost reports.

(C)(i) In organizations with multiple levels of management, costs incurred at levels above the individual facility in Arkansas are allowable only if the costs were incurred in the provision of materials, supplies, or services used by the facility staff in the conduct of normal operations relating to recipient care. In addition, the facility will make available immediately upon request adequate documentation to demonstrate that the costs satisfy the following criteria:

(a) The expense does not duplicate other expenses;

(b) The expense is not incurred for personal or other activities not specifically related to the provision of long-term care; and

(c) The expense does not exceed the amount that a prudent business operator seeking to contain costs would incur.

(ii) If at the time of the request, records are in active use or are located in a place which makes immediate access impossible or impractical, the facility must certify that fact in writing and deliver the records within seventy-two (72) hours of the request.

(D) Adequate documentation consists of all materials necessary to

demonstrate the relationship of personnel, supplies, and services to the provision of recipient care. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by Department of Human Services auditors to perform required tests of allowability.

(E) A ceiling is established for compensation of owners, partners or stockholders or employees related to owners, partners, or stockholders, employed by a company managing multiple facilities. That ceiling is calculated as follows: for the first two (2) nursing facilities, the ceiling is set at one hundred fifty percent (150%) of the median wage for nonrelated administrators for nursing facilities having one hundred fifty (150) or more certified beds as provided in subdivision (2) of this section. For the third facility, the allowable cost is raised by twenty percent (20%) of the ceiling for two (2) facilities. For each of the fourth and fifth facilities, the allowable cost is raised by ten percent (10%) of the ceiling for two (2) facilities. Thereafter, for each additional facility, the allowable cost is raised by five percent (5%) of the ceiling for two (2) facilities. The total allowable cost for an employee must not exceed two hundred percent (200%) of the ceiling for two (2) facilities;

(6) Cost to provide routine services. Includes cost that will be incurred in all cost reporting categories. This section identifies items that are generally considered allowable cost and therefore must be furnished by the facility and does not address the proper category for cost reporting purposes. Please refer to the instructions for completing cost reports and the chart of accounts to assist in determining the classification of these items. Items appearing in this listing that are required to be capitalized and depreciated as described in other sections should be treated accordingly. The cost of items that are rented or leased must be reported on the cost report as equipment rental. Cost includes but is not limited to:

(A) Urological, ostomy, and gastrostomy supplies not billable under Medicare Part B;

(B) Intravenous (I.V.) or subcutaneous tray, connecting tubing, and needles;

(C) General medical supplies stocked on floor in gross supply and distributed in small quantities, including isopropyl alcohol, hydrogen peroxide, applicators, cotton balls, and tongue depressors;

(D) Items furnished routinely and relatively uniformly to all residents, such as water pitcher, glass and tray, wash basin, emesis basin, denture cups, bedpan, urinal, thermometer, and hospital type resident gowns;

(E) First aid supplies, including small bandages, merthiolate, mercurochrome, hydrogen peroxide, and ointments for minor cuts and abrasions, etc.;

(F) Enema supplies, including equipment, solutions, and disposable enemas;

(G) Douche supplies, including vaginal or perineal irrigation equipment, solutions, and disposable douches;

(H) Special dressings, including gauze, four-inch by four-inch (4" x 4") ABD pads, surgical and micropore tape, telfa gauze, ace bandages, and cast materials;

(I) Administration of oxygen, related equipment, and medications including oxygen, oxygen concentrators, cannulas, mask, connecting tubing, IPPB, Pulmo-Aide, nebulizers, humidifiers, and related respiratory therapy supplies and equipment;

(J) Pressure relieving devices including air or water mattresses or pads, fleece pads, foam pads, and rings;

(K) Disposable diapers and other incontinence items used as a means of caring for incontinent residents;

(L) Special diets, salt and sugar substitutes, supplemental feedings, special dietary preparation, equipment required for preparing and dispensing tube and oral feedings, and special feeding devices;

(M) Daily hair grooming/shaving performed by a facility staff member. Does not include service performed by licensed barber or beautician except as an employee of the facility;

(N) Comb, brush, toothbrush, toothpaste, toothettes, lemon glycerin swabs, denture cream, razor, razor blades, soaps and breath fresheners, mouthwashes,

deodorants, disposable facial tissues, sanitary napkins, and similar personal hygiene items. Residents who choose not to use the brand furnished by the facility must purchase their own items, and the costs of the items are not allowable costs;

(O) Personal laundry services for residents (does not include dry cleaning);

(P) Equipment required for dispensing medications, including needles, syringes, paper cups, and medicine glasses;

(Q) Equipment required for simple tests and examinations, including sphygmomanometers, stethoscopes, clinitest, acetist, dextrostix, scales, and glycometer;

(R) Equipment required by the Department of Human Services for licensure which is available for use by all residents. Includes trapeze bars and overhead frames, foot boards, bed rails, cradles, wheelchairs, geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, and traction equipment;

(S) Other equipment required to adequately care for residents including suction machines, connecting tubing, catheters, suture removal trays, airways, infusion arm boards, sun or heat lamps, chest or body restraints, and slings;

(T) Food and nonalcoholic beverages, dietary and food service supplies, and cooking utensils;

(U) Housekeeping supplies, office supplies, and materials and supplies for the operation, maintenance, and repair of buildings, grounds, and equipment; and

(V) Equipment and supplies to meet the activity needs of residents as required by state rules and federal regulations including the needs of room-bound residents;

(7) Drugs.

(A) All drugs furnished by a facility must be administered in conformity with a physician's written order or prescription.

(B) Over-the-counter drugs (PRN or routine) not covered by the prescription drug program are allowable cost items. These include but are not limited to

simple pain relievers, antacids, mouthwashes, simple laxatives and suppositories, simple cough syrups, antidiarrheal medications, insulin, and insulin needles (regardless of frequency).

(C) Herbal supplements and remedies are not allowable;

(8) Cost of specialized rehabilitative services including physical, speech, occupational, and mental health, in facilities provided by licensed therapist when such treatment is ordered by a physician. However, these costs will not include the direct cost of services reimbursed by Medicare Part A, Medicare Part B, or other third-party payer;

(9) Utilities. This includes electricity, natural gas, fuel oil, water, wastewater, garbage collection, and telephone. The costs of staff personal calls and individualized resident telephone services including long distance are not allowable;

(10) Property and equipment expenses. Note. Effective January 12, 2001, the reimbursement methodology for nursing facilities changed to a cost-based facility specific rate which included a fair market rental component to reimburse for property and equipment cost in lieu of actual cost and/or lease payments. Allowability or unallowability of costs as described below will not affect nursing facility reimbursement rates. Nevertheless, nursing facilities must continue to report costs in the manner described below in order to continue to maintain historic cost records. Actual reimbursement to providers will be made in accordance with the rules established in 20 CAR § 579-205(1).

(A) Amortization expense. Costs associated with the origination of a loan allowable under this section will be allowable if amortized over the life of the loan. Costs associated with early retirement of a loan allowable under this section may be allowable. If the amount of the interest plus any unamortized origination fees or prepayment penalties do not exceed the maximum amount of allowable capital interest that would have been allowed had the debt not been paid off, then all of the interest and unamortized costs and other prepayment penalties can be claimed as part of the interest expense for the year. If the unamortized fees and prepayment penalties plus interest exceed the amount that would have been allowed, then any excess can be

carried forward and claimed for a period of up to five (5) years so long as total interest expense and unamortized fees and prepayment penalties do not exceed the interest amount that would have been allowable under the previous financing arrangement.

(B)(i) Depreciation expense. Depreciation on the facility's buildings, furniture, equipment, leasehold improvements, and land improvements.

(ii) Depreciation on capital assets, including assets for normal standby or emergency use in which the facility is the record title holder and which assets are used to provide covered services to medical assistance recipients, will be allowable subject to the following conditions:

(a)(1) Generally accepted accounting principles incorporating the straight-line method of depreciation must be used. Accelerated methods of depreciation are not acceptable. Facilities must follow American Hospital Association Guidelines for Depreciation as the basis for calculation of straight-line depreciation. Capitalization is not required for minor equipment costing less than two thousand five hundred dollars (\$2,500) per item. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used, i.e., direct care cost component or indirect, administrative, and operating component. It is not required to deduct salvage value from the cost of the asset for the purpose of calculating depreciation. Component depreciation for physical structures is not acceptable.

(2) Depreciation expense for the year of acquisition and the year of disposal can be computed by using:

(A) The half-year method; or

(B) The actual time method;

(b) The method and procedure for computing depreciation must be applied from year to year on a consistent basis;

(c) The assets shall be recorded at cost. Cost during the construction of an asset, such as architectural, consulting, and legal fees, interest, etc., must be capitalized as a part of the cost of the assets. When an asset is acquired by trade in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid;

(d) Leasehold improvements may be depreciated over the asset's useful life or the remaining life of the lease, whichever is less;

(e) Losses realized from the reasonable disposal or transfer of depreciable assets are a reported cost. Gains realized from the disposal or transfer of depreciable assets are revenue adjustments to be deducted from depreciation costs;

(f) As a basis for reporting depreciation on capital building construction or renovation costs exceeding five hundred thousand dollars (\$500,000), prior approval of the Arkansas Health Services Agency must be secured to meet the requirements of Section 1122 of Federal Social Security Act. If the prior approval is not obtained, no depreciation cost will be allowed for expenditures for such capital building construction or renovation, unless such approval is subsequently received, although operational costs will be considered as a regular expense;

(g) Where purchase of a facility or improvements thereto are financed by tax exempt bonds, the acquired property, plant, or equipment must be capitalized and depreciated over the life of the asset. The depreciation and not the installment payment is considered an allowable cost. The amortization of interest in accordance with the terms of the bond issue is an allowable cost. Where the principal amount of the bond issue was expended in whole or in part on capital assets which fail to meet the requirements above regarding eligibility for depreciation, the includable depreciation shall be proportionately reduced;

(h) Fixed asset records shall be maintained. The records shall include: the depreciation method, a description; the date acquired; cost; depreciable cost; estimated useful life; depreciation for the year and accumulated depreciation. Salvage value is not required to be maintained; and

(i) A funded depreciation account for future replacement of assets must be maintained for depreciation allowed on assets obtained through federal or state funds or grants, e.g., legacy foundation grant, Hill-Burton grants, etc.

(C)(i) Interest expense includes interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the facility's land, buildings, and/or furniture and equipment. Intracompany/intercompany

transactions should be handled according to generally accepted accounting principles.

(ii) To be allowable under the Medicaid Program, interest must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of funds are required, identifiable in the provider's accounting records, related to the reporting period in which costs are incurred, necessary to the operation, maintenance, or acquisition of the provider's facilities, and be incurred for a purpose related to resident care.

(iii) Allowable interest expense on loans from a related party is limited to the maximum interest rate equal to the prime commercial rate reported by the St. Louis Federal Reserve Bank.

(iv) Interest applying to mortgages on the property and plant of the facility will be included in allowable costs. Where a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as cost, the mortgage interest paid by the related organization is allowable to the provider as cost, as are the other costs of ownership of the leased facility such as property insurance, depreciation, and real estate taxes.

(v) Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the open market existing at the time the loan was made will be recognized. Allowable costs for interest may not exceed limitations set by any state or federal law or the law of the state in which the loan originated. Allowable costs for interest may not include penalties or late charges.

(D) Cost of fire and casualty insurance on facility buildings and equipment.

(E) Taxes levied on the facility's land, buildings, furniture, and equipment.

(F) Cost of leasing the facility's real property. The lease must classify as a true operating lease. Any lease that transfers substantially all of the benefits and risks of ownership should be accounted for as the acquisition of an asset and the incurrence of an obligation by the lessee in accordance with generally accepted accounting principles.

(G) Cost of leasing the facility's furniture and equipment.

(H) Sale and leaseback transactions will not be recognized for

reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

(I) Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities, excluding Arkansas Health Center, is capped at two thousand five hundred dollars (\$2,500) per licensed bed as of the end of the cost reporting period;

(11) Transportation costs.

(A) The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

(B) If the facility acquires and maintains one (1) or more vehicles designed and equipped to carry more than seven (7) passengers, one (1) or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

(C) The per mile rate allowable by the Department of Finance and Administration to reimburse state employees for travel by private aircraft;

(12) Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care;

(13) Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

(A) Located within the State of Arkansas or a contiguous state within two hundred fifty (250) miles of the facility;

(B) Related to recipient care; and

(C) Related to the employee's duties in the facility;

(14) Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one (1) facility, at a location central to such facilities. Allowable costs are limited to a maximum of four (4) meetings per calendar or facility fiscal year, are limited to meetings during which facility management and operations related to resident care constitute the majority of business discussed, and may not exceed the amounts payable to members of state boards pursuant to Arkansas Code §§ 25-16-901 and 25-16-902 for travel to and attendance at state board meetings;

(15)(A) Interest expense on working capital loans. Working capital is defined as funds borrowed to meet the expenses of daily operations. Working capital interest expense is not allowable on loan amounts up to and including the amount of equity withdrawn from the facility during the six (6) months preceding the working capital loan or during the term of the working capital loan. For purposes of this subdivision (15), equity withdrawals do not include withdrawals necessary to pay allowable facility salaries or withdrawals necessary to make federal and state tax payments. The allowance for federal and state taxes will be limited to no more than thirty percent (30%) of the net income reported on the most recent Form 5.

(B) Amounts paid in excess of allowable salaries will be considered a withdrawal of equity. Net income must be adjusted for salaries in excess of allowable.

(C) No working capital interest will be allowed when the facility has cash on hand equal to or greater than two (2) months' operating expenses; and

(16) Costs determined by the Department of Human Services audit staff to have been claimed under circumstances identical in all material respects to costs that have been allowed by final appeal decision. An appeal decision is final if no additional appeal is provided for by law or if the time to file an additional appeal has expired.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-303. List of unallowable costs.

The following list of unallowable costs is not all inclusive, but rather serves as a general guide and clarifies certain key expense areas. The absence of a particular item does not necessarily mean that it is an allowable cost. Except where specific exceptions are noted, the allowability of all costs is subject to the general principle specified in 20 CAR § 579-301:

(1) Compensation in the form of salaries, benefits, or any form of perquisite provided to owners, partners, officers, directors, stockholders, employees, or others who do not provide services necessary to facility operations or recipient care;

(2) Personal expenses not related to the provision of long-term recipient care in a facility;

(3) Costs for a private duty nurse or sitter;

(4) Forms of compensation that are not clearly enumerated as to dollar amount or which represent profit distributions;

(5) Management fees paid to a related organization that exceed the actual cost of materials, supplies, or services;

(6)(A) Costs of advertising to the general public which are intended to attract residents to the facility, for example, advertising in the yellow pages of the telephone directory exceeding the advertisement that is free with a business line.

(B) The cost of advertising related to classified advertisements for labor and supplies are allowable costs and should be included in the administrative and operating expenses section;

(7)(A) Business expenses not related to the care of recipient or necessary for the operation of a long-term care facility.

(B) This includes all costs of:

(i) Business investment activities;

(ii) Stockholder and public relations activities; and

(iii) Farm and ranch operations;

(8) Political contributions and lobbying expenses, including any portion of professional or other association dues or fees which is used for these purposes;

(9)(A) Depreciation and amortization of unallowable costs.

(B) This includes amounts in excess of those resulting from the straight-line method, capitalized lease expenses in excess of actual lease payments, and amortization of goodwill or any excess above the actual value of physical assets at the time of purchase;

(10) Amounts donated to charitable or other organizations;

(11) Dues to all types of organizations and associations not related to facility resident care;

(12) Entertainment expenses not related to resident care;

(13) Cost of radios and television sets used in the residents' rooms, or cost of providing cable TV to residents' rooms;

(14)(A) Expense incurred for services provided in a facility but not related to long-term recipient care.

(B) This includes:

(i) Meals provided to others than recipients or facility employees as a part of an employment contract;

(ii) Nonmedical rentals;

(iii) Barber and beauty shop operations;

(iv) Canteens and gift shops; and

(v) Vending machines;

(15) Retainers and honorariums;

(16) Fines and penalties for violations of rules, regulations, statutes, and ordinances of all types;

(17) Fundraising and promotional expenses;

(18)(A) Interest expenses on loans pertaining to unallowable items.

(B) Otherwise allowable interest expense on short-term indebtedness must be reduced or offset by interest income as specified in 20 CAR § 579-304;

(19) Insurance premiums pertaining to items of unallowable cost;

(20)(A) Cost of life insurance on officers and key employees of the facility where the company is the direct or indirect beneficiary.

(B) The cost of premiums for term policies on the lives of key officers or employees will be allowable:

(i) Provided that securing such policies was a condition precedent to the provider's obtaining financing to improve resident facilities; and

(ii) When such condition is a customary business practice of the lender.

(C) However, these premiums will be considered allowable only to the extent that coverage equals the unpaid principal balance;

(21)(A) Costs associated with portions of a facility that are not licensed as a nursing facility (NF) or an intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(B) The costs must be allocated between licensed and unlicensed portions of a facility based upon objective measures;

(22)(A) Planning and evaluation expenses for the expansion of an existing facility or for new business opportunities.

(B) The expense will be capitalized and amortized on the records of the appropriate facility if actual construction occurs;

(23) Costs of motor vehicles, except as allowed in 20 CAR § 579-302(11);

(24) Values assigned to the services of unpaid workers and volunteers;

(25) Costs of purchases from a related party which exceed the lesser of the original cost to the related party or fair market value;

(26) Out-of-state travel expenses, except as allowed in 20 CAR § 579-302(13);

(27) Legal and other costs associated with litigation between the provider and the state or federal agencies administering the Medicaid program;

(28) Penalties and insufficient funds charges by banks;

(29) Undocumented cost;

(30) Federal, state, and local income taxes;

(31) Prescription drugs;

(32) Accounts receivable written off as uncollectable, including bad debts incurred from private pay residents, Medicare, or Medicaid recipients;

- (33) Personal telephone service;
- (34) Costs of owning, leasing, or operating boats;
- (35) Costs of chaplaincy training programs;
- (36) Cosmetics;
- (37) Barber and beautician services provided by personnel not employed within the facility;
- (38) Dry cleaning services for residents;
- (39) Salaries, wages, and benefits paid for undocumented or duplicated duties, services, and management activities;
- (40)(A) Interest related to the acquisition and retirement of treasury stock is not an allowable cost.
 - (B) Treasury stock is not an asset and should be carried on the balance sheet as a reduction of equity capital.
 - (C) All costs relating to the retirement of stock shall not be considered allowable.
 - (D) Transactions in stock or equity which benefit stockholders, partners, and ownership interest will not be recognized;
- (41) Interest expense, finance charges, and service charges on loans, mortgages, and bond issues, where the proceeds of such loans, mortgages, and bond issues are used to acquire stock ownership of additional facilities are not allowable costs; and
- (42) Interest on proceeds from loans not necessary for facility operations or used for investments are not allowable costs.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-304. Items that will reduce allowable costs.

(a)(1) Interest income on unrestricted funds will reduce interest expense on all short-term debt not to exceed interest expense.

(2) Short-term debt will be defined as debt having a term of forty-eight (48)

months or less.

(b) Grants, gifts, and income designated by the donor for specific operating expenses must be used as an offset to those specific operating expenses.

(c) Recovery of insured loss.

(d) The cost of the following items should be eliminated. In lieu of determining and eliminating costs, the related income may be used to offset costs:

(1) Income from laundry and linen service;

(2) Income from employee and guest meals;

(3) Income from the sale of drugs to other than residents;

(4) Income from the sale of medical and surgical supplies to other than residents;

(5) Income from the sale of medical records and abstracts;

(6) Income from space rented to employees and others;

(7) Payment received from specialists; and

(8) Payments received from recipients for items not medically necessary to the recipient, i.e., tobacco, soft drinks, personal items, etc.

(e) Rebates and refunds of expenses.

(f) Trade, quantity, time, and other discounts on purchases.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-305. Special items to meet needs of residents of ICF/IID and the Arkansas Health Center Nursing Facility.

(a) In addition to those items listed in 20 CAR § 579-302, the following items will be allowable costs for intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and the Arkansas Health Center Nursing Facility:

(1) Central medical supplies;

(2) Dental services;

(3) Drugs and pharmacy;

(4) Medical services, general physician;

(5) Therapy: physical, occupational, psychiatric, psychological, and speech;
(6) All training and habilitation services whether provided in-house or through contractual arrangements, i.e., vocational training, sheltered workshop, or day activity center; and

(7) Actual costs of use of vehicles will be allowable to the extent that such costs meet the criteria set forth in 20 CAR § 579-302(11).

(b) In addition to the items listed above, the following items are allowable costs for the Arkansas Health Center Nursing Facility:

- (1) Actual costs of ambulance (escort services);
- (2) EEG and EKG services;
- (3) Externs (residents serving internships); and
- (4) Radiology.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-306. Direct provider payment not includable in allowable expenses.

The direct costs of prescription drugs, physician, dental, dentures, podiatry, eyeglasses, appliances, X-rays, laboratory, and any other materials or services for which benefits are offered by direct provider payment plans under medical assistance or Medicare Part B, CHAMPUS, Blue Cross-Blue Shield, various other insurers, or third-party resources are not allowed.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-307. Charges to recipients, relatives, or recipient representatives and solicitation of contributions from Medicaid recipients.

Facilities must not charge recipients, relatives, or recipient representatives for any item included in this part as an allowable cost item. No provider participating in this program can solicit contributions, donations, or gifts directly from Medicaid recipients or

family members. See 42 U.S.C. § 1302a-7b(D), 42 U.S.C. § 1396(a)(g), 42 U.S.C. § 447.15, 42 U.S.C. § 1001, and 42 U.S.C. § 1003.102(b).

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-308. Point of care medication management software applications (POCMM).

(a)(1) Effective November 1, 2007, software applications for medication management employing point of care technology is afforded special treatment for cost reporting periods beginning July 1, 2007.

(2) Characteristics of point of care technology include software applications installed on medication carts allowing point of care based medication management.

(b) The allowable cost of software and associated hardware, used exclusively for this application, required to operate a point of care software application will be treated as direct care cost for cost reporting purposes.

(c) All costs associated with the point of care application must continue to meet all allowable cost principles as defined in this subpart, including capitalization requirements.

(d) Appendix A and Appendix B of this part dated July 1, 1999, include specific instructions on how these costs will be reported on provider cost reports.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Subpart 4. Instruction for Managing Resident Funds

20 CAR § 579-401. Protection of resident funds.

(a)(1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility. But many residents are unable or unwilling to manage their own financial affairs and do not have a responsible party that will manage their funds. In this case, the facility must

hold, safeguard, manage, and account for the personal funds deposited with the facility.

(2) The facility will manage the personal allowance funds for residents when a responsible third party does not exist to handle these funds and the following circumstances exist. Each of these situations must be documented in writing:

(A) When a resident is adjudicated by state law as incompetent;

(B) When the resident's file contains a physician's statement that the resident is not capable of managing his or her own funds;

(C) Residents who have no one to manage their financial interest and request the home to do so; or

(D) Residents whose family requests the facility to manage their funds.

(b)(1) When the facility assumes the responsibility for managing a resident's personal funds, withdrawals by family members should not be allowed.

(2)(A) If the family makes purchases on behalf of the resident, the family can be reimbursed from the resident trust fund by presenting a receipt to the trust fund custodian.

(B) This transaction should be properly recorded in the participant ledger file.

(C) Families who object to following these procedures should be advised that they will have to assume responsibility for managing the resident's money.

(D) This provision should be fully explained to the appropriate family members when the participation in the resident trust fund begins.

(3) The forms referenced in this subpart can be found in Section V of the Arkansas Medicaid Provider Manuals by clicking the hyperlink within this sentence.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-402. Responsibilities of the facility.

(a)(1) The facility must establish and maintain a system that ensures a full, complete, and separate accounting of each resident's funds entrusted to the facility.

(2) An acceptable accounting system is described below.

(b) Resident funds cannot be commingled with facility funds or with the funds of any person other than another resident.

(c)(1) The facility must deposit any Medicaid resident's personal funds in excess of fifty dollars (\$50.00) into an interest bearing account that:

(A) Is separate from any of the facility's operating accounts; and

(B) Credits all interest earned on resident's funds to that account.

(2) In pooled accounts, there must be a separate accounting for each resident's share.

(d) Quarterly statements must be provided to each resident indicating account activity.

(e) The facility is required to notify each resident that receives Medicaid benefits:

(1) When the amount in the resident's account reaches two hundred dollars (\$200) less than the Supplemental Security Income resource limit for one (1) person; and

(2) That, if the amount in the account in addition to the value of the resident's other nonexempt resources, reaches the Supplemental Security Income resource limit for one (1) person, the resident may lose eligibility for Medicaid or Supplemental Security Income.

(f) The facility will convey funds upon the death of a resident in the manner prescribed in 20 CAR § 579-404.

(g) Personal funds cannot be charged for any item or service which payment is made under Medicaid or Medicare.

(h) Individuals handling personal funds must be bonded.

(i) The facility will be responsible for any fund shortages or failure to document account transactions by failing to collect or retain appropriate receipts or journals.

(j)(1) The facility shall provide upon admission a Beneficiary Designation Form that shall only be completed by the resident at the time of admission, identifying to whom the resident trust fund will be distributed in the event of death.

(2) The form must be completed in the presence of two (2) witnesses who

shall affix their signatures to the form as witnesses.

(3) If completed, the Beneficiary Designation Form shall remain permanently in the resident's file.

(4) No licensee, owner, administrator, employee, or representative of a long-term facility shall be named as a beneficiary to such funds.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

20 CAR § 579-403. Accounting system requirements.

The facility must account for each resident's money in such a fashion as to safeguard the money and avoid theft and loss. The system outlined below is designed to maximize security and maintain records sufficient to properly account for personal funds. Although the facility's system does not have to be identical to the system outlined below, it must contain the major components and ensure the integrity and accountability of personal funds:

(1) Participant ledger file.

(A)(i) A ledger account must be maintained for each participant in the resident trust fund.

(ii) This record must reflect all activity (deposits and withdrawals) involving the resident.

(B) Separate balances must be maintained for amounts deposited into separate accounts.

(C) Do not destroy completed or closed files, as each one is a permanent record needed to document the activity in the resident's account.

(D)(i) The facility must ensure that account balances do not go negative.

(ii) Negative balances will be made up by the facility;

(2) Collective resident bank account (checking).

(A) The collective bank account is a single account for resident trust fund money.

(B) The records in the participant ledger file keep track of each resident,

therefore separate resident checking accounts are not necessary.

(C) This account must be separate and distinct from all nursing home accounts.

(D) All checks written on this account must be for resident expenditures only.

(E)(i) A register of all account activity must be maintained.

(ii) The balance per register and balance per bank statement should be reconciled on the bank statement and retained.

(iii) Entries on the register should reference the resident and the source.

(F) If this account is interest bearing, the facility must establish an equitable method for distributing interest earned on the account to the residents participating in the resident trust fund.

(G) Checks written on this account must then be posted to the appropriate participant ledger account;

(3) Interest bearing accounts (savings) — Applicable to nursing facility class only.

(A) Federal regulation requires that resident funds in excess of current needs be deposited into an interest bearing account.

(B) When a participant's balance in the collective checking account reaches a balance of fifty dollars (\$50.00), any additional funds must be placed into an interest bearing account.

(C) For simplicity, we recommend that a separate account be opened for each resident, but this is not required.

(D) If the facility decides to open a collective interest bearing account, the facility must:

(i) Maintain balances for each participant in their participant ledger file; and

(ii) Establish an equitable method for distributing interest earned on the account;

(4) Cash maintained on hand (petty cash).

(A) To accommodate the residents' needs for cash money, the facility must maintain a cash box or drawer containing petty cash.

(B) The petty cash fund should be an imprest system in that the fund always contains cash or petty cash journal entries (receipts) totaling the approved petty cash balance.

(C) The petty cash fund is established by writing a check on the residents' collective bank account, cashing it, and placing the proceeds into the cash box or drawer.

(D) The size of the petty cash fund depends on the number of participants, their daily cash needs, and the frequency that the fund can be replenished.

(E)(i) As cash is distributed to participants from the petty cash fund, the transaction must be recorded on a petty cash journal.

(ii) The participant should sign the journal verifying that a distribution was made.

(iii) Distribution to incompetent participants must be witnessed by a staff member other than the person managing the fund.

(F)(i) As necessary, the fund should be replenished back to the original balance of the fund.

(ii) At the point that the fund is replenished, petty cash activity as recorded in the petty cash journal should be posted to the participant's ledger file.

(G) Please remember that this petty cash fund is for participating residents only and should not be used for any other purpose.

(H) Petty cash funds should be kept secure at all times;

(5) Reconciliation of all funds.

(A) The facility must reconcile all account balances per the participant ledger file to all petty cash and bank account balances on a monthly basis.

(B) Any shortage identified must be made up by the facility;

(6) Receipt file.

(A) Receipts must be retained for any distribution made from any resident

funds account.

(B) All receipts must be documented with:

- (i) The name of the resident;
- (ii) The date of the receipt;
- (iii) The amount; and
- (iv) What the money was spent for.

(C) A folder must be maintained for each participant in the fund in which to put his or her receipts.

(D)(i) The petty cash journal will serve as the receipt for cash money distributed to participants.

(ii) The petty cash journal must be retained for this purpose;

(7) Procedures for creating a participant ledger file:

(A) The facility should retain written authorization from the resident, family, or guardian that the facility is authorized to manage the resident's personal funds;

(B) Create a ledger account for each participant in the fund;

(C)(i) Record the original transaction on the participant's ledger account indicating the date and amount.

(ii) Indicate in the description column "beginning balance";

(D) Deposit the resident's money into the collective trust fund bank account; and

(E) Prepare a receipt file and retain all receipts for this participant; and

(8) Procedures for checking a participant out of the trust fund account:

(A)(i) Determine the participant's balance per the participant ledger file.

(ii) Ensure that all activity including petty cash transactions have been posted to the participant ledger file;

(B)(i) Record the closing distribution on the participant's ledger account, indicating the date and the amount.

(ii) Indicate in the description column "to close account";

(C) Write a check on the collective trust fund bank account payable to the

resident or other appropriate person in the case of a deceased participant; and

(D)(i) If possible, the resident or his or her representative should sign the authorization for expenditures column of the participant's ledger account.

(ii) If the resident has already left, or in the case where the resident is deceased, write the address where you sent the check in the "description" column.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Codification Notes. This section as promulgated prior to codification into the Code of Arkansas Rules contained in subdivision (1) the following provision, which was removed from the text since the referenced page was repealed in a prior promulgation: "Page 5-6 identifies the required detail for each file."

20 CAR § 579-404. Treatment of deceased resident personal trust fund.

(a)(1) In the event of the death of a resident, the facility administrator shall within thirty (30) days of the resident's death provide an accounting and shall return all refunds and funds held in trust as detailed below.

(2)(A) The administrator must determine if a personal representative has been appointed for the resident.

(B) If one has been appointed, then the personal trust funds shall be disbursed to that personal representative.

(C) If no such personal representative exists, then the facility administrator should disburse the funds to the named beneficiary designated by the resident on the form provided by the long-term care facility or surviving spouse.

(3)(A) If a personal representative, surviving spouse, or named beneficiary does not exist or cannot be located at the time of disbursement, the facility administrator shall deposit the funds into an interest bearing account in a bank, savings and loan association, trust company, or credit union located in this state and, if possible, located within the same county in which the facility is located.

(B) The long-term care facility needs to maintain only one (1) account in

which the trust funds amounting to less than one hundred dollars (\$100) of deceased residents are placed.

(C) However, it shall be the obligation of the long-term care facility to maintain adequate records to permit compilation of interest due each individual resident's account.

(D) Separate accounts shall be maintained with respect to trust funds of deceased residents equal to or in excess of one hundred dollars (\$100).

(E) The facility shall maintain such account until such time as the trust funds are disbursed pursuant to the provisions of Arkansas's Probate Code.

(b)(1) At the time the funds are disbursed, the nursing facility should notify the Department of Human Services of the account on the Deceased Resident Personal Trust Fund Form.

(2) If the resident trust fund is disbursed to a personal representative, a surviving spouse, or a named beneficiary, a Beneficiary Receipt Form should be completed and a copy submitted along with the Deceased Resident Personal Trust Fund Form.

(c) These forms should be completed and submitted to:

Arkansas Department of Human Services
Third Party Liability
Estate Recovery
P.O. Box 1437 Slot 296
Little Rock, AR 72203-1437

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Subpart 5. Instructions for Daily Midnight Census

20 CAR § 579-501. Daily midnight census.

(a)(1) Long-term care facilities are required to maintain a daily midnight census of residents in their facility.

(2) Resident day information must be accumulated in a clear, accurate, and auditable format.

(3) Resident day information is an important component of the cost reporting process.

(4)(A) The daily midnight census documents resident day information stated on the facility's cost report.

(B) This information must be retained by the facility for no less than five (5) years following the date cost reports are submitted to the Division of Medical Services.

(C) Facilities that do not maintain accurate and auditable census information are in violation of their provider agreement and may be subject to civil penalty.

(b)(1) The codes and form located in Section V of the Arkansas Medicaid Provider Manuals provide an easily understood method for accumulating daily census information.

(2) The provider may utilize the codes and form or may construct their own form which contains all elements of the referenced form.

(3) The codes and form can be found by clicking the hyperlink, "Section V".

(c)(1) An actual physical census of a facility's residents should be conducted each midnight and recorded on the daily census form.

(2) This ensures that the day of admission is included as a resident day while the day of discharge is not.

(d)(1) Facilities that certify that occupancy levels are eighty-five percent (85%) or greater will be paid up to five (5) consecutive days for a leave of absence (LOA) to the hospital.

(2)(A) The date on which the provider must meet occupancy requirements depends on their billing method.

(B) Providers billing on a TAD must certify eighty-five percent (85%)

occupancy on the last day of the month the LOA occurred.

(C) Providers billing on an electronic billing system must certify eighty-five percent (85%) occupancy for the last day of the month previous to the LOA.

(e) Facilities may bill for up to fourteen (14) consecutive days for therapeutic home visits regardless of the occupancy rate.

(f)(1) LOA days paid for both hospital and therapeutic home visits must be properly identified on the daily census.

(2) These days are included in resident day totals for cost reporting purposes.

Authority. Arkansas Code §§ 20-76-201, 20-77-107, 25-10-129.

Appendix A. Instructions for Filing Long-Term Care Nursing Facility Cost Report

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/265/20CARpt.579AppendixA.pdf>

Appendix B. Instructions for Filing Long-Term Care ICF/IID Cost Report

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/266/20CARpt.579AppendixB.pdf>

Appendix C. Instruction for Managing Resident Funds

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/267/20CARpt.579AppendixC.pdf>

Appendix D. Instructions for Daily Midnight Census

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/268/20CARpt.579AppendixD.pdf>

Appendix E. Codes for Completing Daily Midnight Census

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/269/20CARpt.579AppendixE.pdf>