I. Cost Finding and Cost Reporting

A. Each provider participating in the Florida Medicaid program shall submit a uniform cost report and related documents required by this Plan. The electronic cost report and revised instructions must be used. To be considered a complete submission, the electronic version of the cost report, one hard copy of the cost report, the certification page, supplemental schedules and attachments, and the accountant’s compilation letter must all be received by the Agency for Healthcare Administration (AHCA), Bureau of Medicaid Program Finance, Audit Services, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. Cost reports are due to AHCA, Bureau of Medicaid Program Finance, Audit Services, five months after the close of the provider’s cost reporting year. Extensions will not be granted.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this Plan for determination of allowable costs. For a new provider with no cost history in a newly constructed facility, an existing provider entering the program, an existing provider in a newly constructed replacement facility, or a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Florida Medicaid program, the interim operating, direct care, and indirect care cost per diems shall be the lesser of: the effective class reimbursement ceiling based on section V.B.13, the budgeted operating, direct care, and indirect care cost per diems approved by AHCA based on section III, or the new provider target limitation. The new provider target limitation for a new provider with no cost history in a newly constructed facility or an existing provider entering the program shall be the average operating and indirect care per diem excluding the Medicaid Adjustment Rate (MAR) in the region in which the facility is located plus 50 percent of the difference between the average region per diem (excluding MAR) and the facility’s effective class.
ceiling. The new provider target limitation for existing providers in a newly constructed replacement facility shall be the greater of the above new provider target limitation or their current operating and indirect care cost per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility’s effective class ceilings. The average region per diem is calculated by taking the sum of all operating, direct care, and indirect care per diems within the region divided by the number of facilities within the region. The new provider target limitation for a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Florida Medicaid program shall be the previous provider’s operating and indirect care cost per diem (excluding MAR), plus 50 percent of the difference between the previous provider’s per diem (excluding MAR) and the effective class ceiling. The above new provider target limitation, whether based on the region average per diem or the previous provider’s per diem, shall apply to all new providers with a Florida Medicaid certification. The new provider target limitation above, whether based on the region average per diem or the previous providers' per diem, which affects providers already in the Florida Medicaid program, shall not apply to these same providers beginning with the rate period in which the target reimbursement provision in section V.B.14 does not apply. The new provider target limitation shall apply to new providers entering the Florida Medicaid program, even if the new provider enters the program during a rate period in which section V.B.14 does not apply. New provider target limitations applicable to the first rate period a new provider enters the program shall be the basis for calculating subsequent rate period new provider target limitations for that same provider through the following calculation:

Establish the target reimbursement for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost in section I.B from the previous rate period, excluding the MAR with the quantity:
In the above calculation, the 2.0 shall be referred to as the provider specific inflation multiplier. The direct care component shall not be limited to the new provider target limitation described above. The new provider target limitation shall not fall below 75 percent of the cost-based class ceiling for each rate setting as calculated in section V.B.12.

For new providers who enter the program operating a facility that had been previously operated by a Florida Medicaid provider, the property reimbursement rate shall be established per sections V.D.3 and 4. The property cost per diem for a provider with a newly constructed facility or replacement facility shall be the lesser of the budgeted fair rental value rate approved by AHCA based on section V.D, or the applicable fair rental value based upon the cost per bed standard that was in effect six months prior to the date the facility was first put in service as a nursing facility but not prior to January 1, 1972. Return on equity (ROE) or use allowance per diems shall be the budgeted rate approved by AHCA per section III. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but not more than 18 months. Cost reporting periods shall be for periods of 6 months or more but not more than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations. For changes of ownership or licensed operator, the provider is required to file an initial cost report.

C. The cost report shall be prepared using the electronic cost report described in section I.A, and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA). The methods of
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

reimbursement are in accordance with Title XVIII of the Social Security Act (SSA) and Center for Medicare and Medicaid Services (CMS) Publication 15-1 (CMS-PUB.15-1) incorporated herein by reference except as modified by the Florida Title XIX Long-term Care Reimbursement Plan and state of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The certified public accountant (CPA) preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards and AICPA statements on auditing standards. Cost reports that are not signed by a certified public accountant or not accompanied by a separate letter signed by a CPA shall not be accepted.

D. Providers may elect, with prior approval from AHCA, Bureau of Medicaid Program Finance, Audit Services, to change their current fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same fiscal year end. All prior year cost reports must be submitted to and accepted by AHCA before the current year cost report may be submitted and accepted for rate setting by AHCA.

E. Cost reports submitted after the due date and after the rate setting acceptance cutoff date for the first rate setting for which the cost report could have been used if it had been received on the cost report due date shall be late tested. The late test shall consist of recalculating the per diem rates for the first rate setting after the due date for the cost report for which the cost report could have been used if the cost report had been received on the cost report due date and all subsequent rate periods. If the new cost report sets a lower per diem rate for a rate period as compared to the rate previously set, then the providers' rate for that rate period shall be calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. If the new cost report sets a higher per diem rate for a rate period as compared to the rate previously set, then the
late tested cost report shall not be used for that rate period. If a provider submits more than one late cost report at the same time, the cost reports shall be late tested in fiscal year end date order. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate period had it been submitted timely, then the provider's rate for that rate period shall be calculated using the new cost report, and full payment at the recalculated rate shall be effective retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft, or wind.

F. A provider that has been receiving an interim reimbursement rate, which voluntarily or involuntarily ceases to participate in the Florida Medicaid program or experiences a change of ownership or operator, shall file a final cost report in accordance with section 2414.2, CMS-PUB.15-1. The cost report is to be based on financial and statistical records maintained by the provider as required in Title 42 Code of Federal Regulations (CFR), 413.24 (a), (b), (c), and (e). Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of costs and other records in accordance with CMS-PUB.15-1, which pertain to the determination of reasonable costs and shall be capable of and available for auditing by state and federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of five years following the date of submission of the cost report to AHCA.

G. Records of related organizations as identified by 42 CFR 413.17 shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).
H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following
the date of submission of such reports and shall maintain those reports pursuant to the record-
keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes (F.S).

I. Chart of Accounts: All providers must use the most recent version of the standard chart of
accounts to govern the content and manner of the presentation of financial information to be
submitted by Florida Medicaid long-term care providers in their cost reports. The standard chart
of accounts includes specific accounts for each component of direct care staff organized by type
of personnel and may not be revised without the written consent of the Auditor General.

J. Cost reports must include the following statement immediately preceding the dated signature of
the provider’s administrator or chief financial officer: “I certify that I am familiar with the laws
and regulations regarding the provision of health care services under the Florida Medicaid
program, including the laws and regulations relating to claims for Florida Medicaid
reimbursements and payments, and that the services identified in this cost report were provided in
compliance with such laws and regulations.”

K. AHCA reserves the right to refer providers found to be out of compliance with any of the policies
and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for
investigation.

L. Providers are subject to sanctions pursuant to sections 409.913(15)(c), F.S., and 409.913(16)(c), F.S., for late cost reports. The amount of the sanctions can be found in Rule 59G-9.070, F.A.C. A
cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Audit
Services on the cost report due date. Sanctions shall commence 60 days after the cost report due
date. If a provider submits a cost report late because of emergency circumstances, then the
provider shall not be subject to the sanctions. Emergency circumstances are limited to loss of
records from fire, flood, theft, or wind.
II. Audits and Desk Reviews

Cost reports submitted by providers of nursing facility care, in accordance with this Plan, are subject to an audit or desk review on a random basis or at any time AHCA has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. General Description of AHCA’s Procedures for Audits

1. Primary responsibility for the audit of provider cost reports shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 will be met.

2. All audits shall be based on generally accepted auditing standards of the AICPA.

3. Upon completion of each audit, the auditors shall issue a report that meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to reimbursement for long-term care facilities. All reports shall be retained by AHCA for three years.

4. The provider’s copy of the audit report shall include all audit adjustments and changes, the authority for each, and all audit findings. The audit report shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

Upon receipt of a cost report from the provider, prepared in accordance with instructions furnished by AHCA, AHCA will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing by the AHCA audit office or CPA firm assigned to perform the audit or desk review.
1. Upon completion of an audit or desk review and before publication of the audit or desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least 10 days before the exit conference. If the provider fails to schedule an exit conference within 20 calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in AHCA’s office in Tallahassee.

2. Following the exit conference, the provider has 60 calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. Any documentation received after the 60 day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the 60 day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood, or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested to the address of the nursing facility and to the attention of the administrator. The provider shall have 21 calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustments or findings contained in the report by requesting an administrative hearing in accordance with section 120.57, F.S., and Chapter 28.106, F.A.C. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively demonstrate the entitlement to the Florida Medicaid reimbursement. Except as otherwise provided in this Plan, Chapter 28-106, F.A.C. shall be applicable to any administrative proceeding under this Plan.
4. Collection of overpayments will be in accordance with section 414.41, F.S. and Rule 59G-6.010, F.A.C.

III. Allowable Costs

A. All items of expense shall be included on the cost report, which providers must incur in meeting:

1. The definition of nursing facilities contained in sections 1919(a), (b), (c), and (d) of the Social Security Act (SSA).

2. The standards prescribed by the Secretary of Health and Human Services (HHS) for nursing facilities in regulations under the SSA in 42 CFR 483, Subpart B.

3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610.

B. All therapy required by 42 CFR 409.33 and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These include physical, audiology, speech pathology, and occupational therapies.

C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS-PUB.15-1 and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under this Plan.

D. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items includes laundry services, nutritional services, personal care services, personal care supplies, incontinence supplies, rehabilitative and restorative care services, durable medical equipment, stock medical supplies, analgesics, antacids, laxatives, vitamins, and wound care supplies. Physician Services, dialysis services, community mental health services, dental services, podiatry services, flu and pneumonia...
injections, visual services, and transportation services are not included in the per diem rate as the rendering provider bills Medicaid directly.

E. Bad debts other than Title XIX of the SSA, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX of the SSA shall be limited to Title XIX of the SSA uncollectible deductible and copayments and the uncollectible portion of eligible Florida Medicaid recipients' responsibilities. Example- Daily rate is $210.00; state pays $190.00 and recipient is to pay $20.00. If Florida Medicaid recipient pays only $15.00, then $5.00 would be an allowable bad debt. All Florida Medicaid Title XIX of the SSA bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Title XVIII of the SSA and Chapter 10, CMS-PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The owner-administrator and owner-assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 or determined by surveyed ranges of compensation conducted by AHCA. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and shall be updated each year by the wage and salary component of the Plan's inflation index. A new salary survey may be conducted at the discretion of AHCA.

2. Limitation of rents:
a. For the purposes of this provision, allowable ownership costs of leased property shall be defined as:

(1) Cost of depreciable assets, property taxes on personal and real property, and property insurance.

(2) Sales tax on lease payments except in cases of related parties.

(3) ROE that would be paid to the owner if he were the provider, as per section III.J.

b. Lease costs allowed for lease contracts existing as of August 31, 1984, shall remain unchanged except for increases specified in the contract entered into by the lessee and lessor before September 1, 1984. If, prior to October 1, 1985, the lessee exercises an option to renew the lease that existed as of August 31, 1984, increases in lease cost for each year of the renewal period shall be limited to the increase in the Florida Construction Cost Inflation Index during the last 12 months. See Appendix B for the computation of this index. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per section V.D.1.

c. Facilities not leased on October 1, 1985:

(1) For facilities that were not leased as of August 31, 1984 and that are operating under a lease agreement commencing on or after September 1, 1984 and before October 1, 1985, the Florida Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the
allowable ownership costs of the leased property per sections III.G.3 through 5.

(2) Annual increases in lease costs for providers in (1) above shall be limited to the increase in the Florida Construction Cost Inflation Index during the last 12 months. See Appendix B for the computation of this index. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per section V.D.1.

d. Facilities leased on or after October 1, 1985:

(1) Providers that leased facilities on or after October 1, 1985, shall be reimbursed for lease costs and other property costs based on the FRVS per section V.D.1. Allowable ownership costs shall be documented to AHCA for purposes of computing the fair rental value. Facilities not currently reimbursed based on the FRVS per section V.D.1 shall not become reimbursed based on the FRVS per section V.D.1, solely due to the execution of a lease agreement between related organizations under section III.F.

(2) In no case shall Florida Medicaid reimburse property costs of a provider who is subject to b, c, d. (1) and e, if ownership costs are not properly documented per the provisions. Providers shall not be reimbursed for property costs if proper documentation of the owner’s costs, capable of being verified by an auditor, is not submitted to
AHCA. The owner shall be required to sign a letter to AHCA that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing facility properties available to auditors or official representatives of AHCA.

(3) Approval shall not be given for proof of financial ability for a provider if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (2).

e. A lease agreement may be assigned and transferred (assumed) for Florida Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984 (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Florida Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.

(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per section V.D.1.

3. **Basis for depreciation and calculation:**
a. Cost - Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3.b and 6. All provisions of the Title XVIII of the SSA and CMS-PUB.15-1 regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets - For purposes of this Plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occur, and if a bona fide sale is established, the provider's basis for depreciation shall be the lesser of the following:

(1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 and determined by an appraiser who meets the requirements of Chapters 61J1-4 and 61J1-6, F.A.C.

(2) The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that began operation after July 18, 1984.

(3) The acquisition cost of such assets to the new owner.

(4) Example 1 - An entity, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $5,000,000. A new owner purchases the facility for $10,000,000. The new owner's basis for depreciation is the lesser of the two, or $5,000,000.

Example 2 - An entity, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $5,000,000. A new
owner purchases the facility for $3,000,000. The new owner's basis for
depreciation is the lesser of the two, or $3,000,000.

4. Limitation on Interest Expense for Property-Related Debt and ROE or Use Allowance

At a change of ownership on or after July 18, 1984, the interest cost and ROE or use
allowance to the new owner shall be limited by the allowable basis for depreciation as
defined per 3.b. The new owner shall be allowed the lesser of actual costs or interest cost
and ROE cost or use allowance in amounts that would have occurred based on the
allowable depreciable basis of the assets. These limited amounts shall be determined as
follows:

a. The portion of the equity balance that represents the owner's investment in the
capital assets shall be limited for purposes of calculating a ROE or use
allowance to the total amount allowed as depreciable basis for those assets as
per 3.b.

b. The amount of interest cost due to debt financing of the capital assets shall be
limited to the amount calculated on the remainder of the allowable depreciable
basis after reducing that allowable basis by the amount allowed for equity in a.
The new owner’s current terms of financing shall be used for purposes of this
provision.

Example 1 - The first owner of record after July 18, 1984 has an acquisition cost
of $6,000,000. The new owner pays $10,000,000 for the facility, makes a down
payment of $2,000,000 and finances $8,000,000 at 5 percent for 25 years. The
basis for depreciation to the new owner is $6,000,000, and the disallowed
portion of the depreciable basis is $4,000,000. Therefore, the allowable equity
attributable to investment in the capital assets is $2,000,000, and interest cost
allowed shall be computed on $4,000,000 ($6,000,000 minus $2,000,000) at 5 percent over 25 years.

Example 2 - If the new owner above had made a down payment of $7,000,000 and financed $3,000,000, the allowable equity would be $6,000,000, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984 shall not be considered allowable costs for the provider’s Florida Medicaid reimbursement purposes, to the extent that such costs were previously reimbursed for that facility under a former owner. Such costs include legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Florida Medicaid certification effective on or after July 1, 1991. Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example below, the reimbursable cost which is considered in rate calculations is the lower of the new facility cost, CON approval, or the Florida Medicaid allowable cost.
H. Recapture of depreciation resulting from sale of assets:

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Title XVIII of the SSA, indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to a provider prior to reimbursement under the FRVS shall be determined as follows:

a. The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1 percent for each month in excess of 48 months participation in the Florida Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 ⅔ year depreciation recapture phase-out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1 percent for each month in excess of 48 months of participation in the Florida Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all
Depreciable assets shall be allocated to the older and new portions of a facility as follows:

1. For each part of the facility, determine the proportion of beds to the facility's total number of beds.
2. Multiply the proportion of beds in that part of the facility by the sales price.
3. The result is the portion of the sales price allocable to that part of the facility.

**Example**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales Price</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>Older Portion of Facility</td>
<td>60 Beds</td>
</tr>
<tr>
<td>Newer Portion of Facility</td>
<td>120 Beds</td>
</tr>
</tbody>
</table>

\[
\begin{align*}
\text{Allocation to older portion} & \quad \frac{60}{180} \times 6,000,000 = \$2,000,000 \\
\text{Allocation to newer portion} & \quad \frac{120}{180} \times 6,000,000 = \$4,000,000 \\
\text{Total Sales Price} & \quad \$6,000,000
\end{align*}
\]

b. The adjusted gross recapture amounts as determined in section a shall be allocated for fiscal periods from January 1, 1972 through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility.

The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.
c. The net recapture overpayment amount, if any, so determined in b, shall be paid by the former owners to the state. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from future payments by AHCA to the buyer until net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation Recapture Resulting from Leasing a Facility or Withdrawing from the Florida Medicaid Program

In cases where an owner-operator withdraws from the Florida Medicaid program as the provider, but does not sell the facility, the depreciation paid by Florida Medicaid to the owner during the time he was the Florida Medicaid provider shall be subject to the depreciation recapture provisions of this Plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Florida Medicaid provider. All owner-providers that withdraw from the Florida Medicaid program shall be required to sign a contract with AHCA creating an equitable lien on the owner's nursing facility assets. This lien shall be filed by AHCA with the clerk of the circuit court in the judicial circuit within which the nursing facility is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this Plan, and the contract shall state that such recapture so determined shall be due to AHCA upon sale of the facility. In the event that an owner-provider withdraws from the Florida Medicaid program, the reduction in the gross depreciation recapture amount calculated in section III.H.1.a shall be computed using only the number of consecutive months that the facility is used to serve Florida Medicaid recipients.
Example - An owner-operator participates in Florida Medicaid for 60 months. He then withdraws from the Florida Medicaid program and leases the facility to a new operator, who enters the Florida Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Florida Medicaid program and operates the facility for another 60 months, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Florida Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be \((60 + 24 - 48) = 36\) months times 1 percent. If a provider fails to sign and return the contract to AHCA, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method:

   1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the provider.

   2. Upon sale of assets, recapture of reimbursement due to indexing under FRVS shall be determined as follows:

      a. The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the provider has been reimbursed under FRVS.

      b. For months 61 and subsequent months, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the provider had Florida Medicaid utilization greater than 55 percent for a majority of the months that the provider was reimbursed under FRVS.
c. Documented costs of replacement equipment purchased subsequent to the date the provider began reimbursement under FRVS shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity

An allowance of a reasonable ROE for capital invested and used in providing patient care is includable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider’s reporting period or portion thereof covered under the Florida Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. ROE shall exclude positive net working capital (an amount greater than zero). For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full ROE payment shall be calculated on 20 percent of the FRVS asset valuation per section V.D.1.e and included in the FRVS rate.

K. Use Allowance

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the Plan as an allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in section J, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including government owned or operated facilities, all provisions of J, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.
L. Legal Fees and Related Costs

In order to be considered an allowable cost of a provider in the Florida Medicaid program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA as it relates to Florida Medicaid audits and Florida Medicaid cost reimbursement cases, including administrative rules, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. The direct care component shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants (CNA) who deliver care directly to residents in the nursing facility. Direct care staff does not include nursing administration, Minimum Data Set (MDS) and care plan coordinators, staff development, and staffing coordinators. There shall be no costs directly or indirectly allocated to the direct care component from a home office or management company for staff who do not deliver care directly to residents in the nursing facility.

N. All other patient care costs shall be included in the indirect care cost per diem rate.
O. Effective April 1, 2009, the Nursing Facility Quality Assessment (NFQA) fee is an allowable cost and shall be included in the cost report with required adjustments. Refer to section V.F of this Plan for specific details of this fee. Nursing facilities may not create a separate line-item charge for the purpose of passing through the assessment to residents.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedure Act, this Plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the Plan.

B. For purposes of establishing reimbursement ceilings, each nursing facility within the state shall be classified into one of six reimbursement classes as defined in sections V.A.2 and 3. Separate operating, direct care, and indirect care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling of $13.6500 for facilities still being reimbursed depreciation and interest per sections III.G.3 through 5 except as noted in section V.B.6.b.

C. The ceilings shall be determined prospectively and shall be effective the first day of the rate period, as described in section V.A. Ceilings shall be set at a level which the State determines to be adequate to reimburse a provider for the allowable and reasonable costs of an economically and efficiently operated facility. The statewide property ceilings shall be set as described in section V.A and V.B. The operating, direct care, and indirect care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating, direct care, and indirect care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates.

D. Supplemental Payments for Special Care
In order to receive a supplemental payment in excess of the class ceilings, a provider must demonstrate to AHCA that unique medical care requirements exist which require extraordinary outlays of funds. Circumstances which shall require such an outlay of funds in order to receive a supplemental payment shall be limited to patients under age 21 with complex medical needs based upon a level of care established by the Agency’s designee. The period of reimbursement in excess of the class ceiling shall not exceed 12 months. Effective September 1, 2017, the period of reimbursement in excess of the class ceiling shall not exceed 13 months. A flat rate shall be paid for the specific patients identified, in addition to the per diem paid to the provider. The flat rate supplemental payment shall be trended forward each rate period using the IHS Healthcare Cost Review indices used to compute the operating and patient care ceilings. These incremental costs shall be included in the cost reports submitted to AHCA, but shall not be included in the calculation of future prospective rates. The cost of the patients shall be adjusted out based upon the flat rate payments made to the provider, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider from the Bureau of Medicaid Policy. The class ceilings may also be exceeded in cases where Florida Medicaid patients are placed by AHCA in hospitals or in non-Florida Medicaid participating institutions on a temporary basis pending relocation to participating nursing facilities, for example, upon closure of a participating nursing facility. The CMS Regional Office shall be notified in writing at least 10 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. AHCA shall extend the class ceiling exception for subsequent allowable periods upon making a determination that a need for the exception still exists and upon providing the CMS Regional Office with another advance written notification as stated above.

E. FRVS shall be used to reimburse facilities for property. To prevent any provider from receiving lower reimbursement under FRVS than under the former method where depreciation plus interest
costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in section V.D.1.h. At that time, a provider shall begin reimbursement under the FRVS. Providers entering the program after October 1, 1985 that had entered into an arm’s length (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985 shall be eligible for the hold harmless clause per section V.D.1.h.

F. The prospectively determined individual nursing facility's rate will be adjusted retroactively to the effective date of the affected rate under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rate.

2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be granted unless the amended cost report shall cause a change of one or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the one percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by AHCA in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report, the date of the first field audit exit conference for the period being amended, or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs.

G. The Florida Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Florida Medicaid costs divided by the Florida Medicaid patient days from the most recent cost report subject to the rate setting methodology in section V.
H. Reimbursement of operating, direct care, and indirect care costs are subject to class ceilings. Property costs are subject to statewide ceilings of $13,650.00 for facilities being reimbursed under sections III.G.3 through 5 except as noted in section V.B.6.b. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per section V.D.1.g. ROE and use allowance are passed through and are not subject to a ceiling.

I. A MAR shall be calculated pursuant to section V.E.

J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine rate setting process:

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition, replacement, allowable lease cost increase or repair would cause a change of one percent or more in the provider's total per diem reimbursement rate. For providers being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on the first day of the rate period per section V.D.1.i.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

   a. If new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that
result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by AHCA and shall be the basis for establishing reasonable cost parameters.

b. In cases where new state or federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

c. Interim rate adjustments shall be granted to reflect increases in the cost of general or professional liability insurance for nursing facilities if the change in cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

d. Interim rates shall not be granted for fiscal periods that have ended, such as after the close of the provider's reporting year in which the additional costs were incurred.

e. Interim rates for the staffing requirements shall not be granted.

3. Interim rate requests must be submitted within 60 days after the costs are incurred, and shall be accompanied by a 12 month budget that reflects changes in services and costs. These interim rate requests shall be submitted to AHCA, Bureau of Medicaid Program Finance, Cost Reimbursement – Nursing Homes, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the
interim rate request. The interim per diem rate shall reflect only the estimated additional
costs, and the total reimbursement rate paid to the provider shall be the sum of the
previously established prospective rates plus the interim rate as limited by the effective
ceiling. A discontinued service would offset the appropriate components of the
prospective per diem rates currently in effect for the provider. Upon receipt of a valid
interim rate request, AHCA, Bureau of Medicaid Program Finance, shall determine
whether additional information is needed from the provider and request such information
within 30 days. Upon receipt of the complete, legible additional information as
requested, AHCA, Bureau of Medicaid Program Finance, shall approve or disapprove the
interim rate request within 60 days. If AHCA, Bureau of Medicaid Program Finance,
does not make such determination within the 60 days, the interim rate request shall be
deemed approved.

4. Interim Rate Settlement

The interim rate settlement will adjust targets from the interim effective date going
forward so the new interim cost, that otherwise would not have been reimbursed, can now
flow through provider specific targets per section V.B.14. The settlement will adjust the
actual Florida Medicaid cost against estimated cost from the effective interim date until
the cost report containing the interim cost is used to set rates. The interim adjustment,
line 5a of the rate sheet, is settled by the following calculation:

```
Schedule S, line 6 of the cost report ÷ Total patient days from interim date until cost report fiscal year end
```

The provider specific target adjustment, line 7a of the rate sheet, is settled by the
following calculation:
Overpayment as a result of the difference between the approved budgeted interim rate and the revised rate using the actual costs of the item shall be refunded to AHCA.

Underpayment as a result of the difference between the budgeted interim rate and the revised rate using the actual costs shall be paid to the provider.

K. Aggregate Test Comparing Florida Medicaid to Medicare

42 CFR 447.272 provides that states must ensure CMS that AHCA’s estimated average proposed payment rate pay no more in the aggregate by category for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate period if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles the following steps shall be taken in order to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate period. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below the initial per diem the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, ROE, taxes, insurance, and home office.

2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Florida Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.
3. If provisions 1 and 2 above are implemented in order to meet the upper limit test, for a period of one year, this Plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

L. Payments made under this Plan are subject to retroactive adjustment if approval of this Plan or any part of this Plan is not received from CMS. The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this Plan not authorized by CMS.

V. Method

This section defines the methodologies to be used by the Florida Medicaid program in establishing reimbursement ceilings and individual nursing facility reimbursement rates.

A. Ceilings

1. Ceilings shall be determined prospectively and shall be effective on the first day of the rate period. The most current acceptable cost reports received by AHCA, Bureau of Medicaid Program Finance, Audit Services by the close of the business day on April 30 of each year, or by the close of the next business day if April 30 fall on a weekend, and the provider’s most recent reimbursement rates shall be used to establish the operating, direct care, and indirect care ceilings. The statewide property ceiling for facilities being reimbursed per sections III.G.3 through 5, pending transition to payments based on the FRVS, shall be $13,6500 except as noted in section V.B.6.b. For those facilities being reimbursed under FRVS, the cost per bed ceiling per section V.D.1.g shall be used.

2. For the purpose of establishing reimbursement limits for operating, direct care, and indirect care costs, four classes based on geographic location and facility size were developed. These classes are as follows:

a. Class 1 Small Size 1 - 100 beds - Northern Florida Counties

b. Class 2 Large Size 101 - 500 beds - Northern Florida Counties
c. Class 3 Small Size 1 - 100 beds - Southern Florida Counties

d. Class 4 Large Size 101 - 500 beds - Southern Florida Counties

For purposes of defining the four reimbursement classes, the "Southern Florida Counties"
shall be comprised of:

<table>
<thead>
<tr>
<th>Broward</th>
<th>Hardee</th>
<th>Monroe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte</td>
<td>Hendry</td>
<td>Okeechobee</td>
</tr>
<tr>
<td>Collier</td>
<td>Highlands</td>
<td>Palm Beach</td>
</tr>
<tr>
<td>Dade</td>
<td>Indian River</td>
<td>Polk</td>
</tr>
<tr>
<td>Desoto</td>
<td>Lee</td>
<td>St. Lucie</td>
</tr>
<tr>
<td>Glades</td>
<td>Martin</td>
<td>Sarasota</td>
</tr>
</tbody>
</table>

All remaining Florida counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

a. Class 5 Small Size 1 - 100 beds - Central Florida Counties

b. Class 6 Large Size 101 - 500 beds - Central Florida Counties

The "Central Florida Counties" shall be comprised of:

<table>
<thead>
<tr>
<th>Brevard</th>
<th>Manatee</th>
<th>Pinellas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardee</td>
<td>Orange</td>
<td>Polk</td>
</tr>
<tr>
<td>Highlands</td>
<td>Osceola</td>
<td>Seminole</td>
</tr>
<tr>
<td>Hillsborough</td>
<td>Pasco</td>
<td></td>
</tr>
</tbody>
</table>

The "Northern Florida Counties" and "Southern Florida Counties" shall be
comprised of the counties enumerated in section V.A.2 less the "Central Florida
Counties" as defined above.

B. Setting Prospective Reimbursement Per Diems and Ceilings

In determining the class ceilings, all calculations for sections V.B.1 through 14 shall be made
using the four classes, and "Northern Florida Counties" and "Southern Florida Counties"
definitions of section V.A.2. All calculations for sections V.B.15 and 16 shall be made using the six classes and "Central Florida Counties" definition of section V.A.3. AHCA shall:

1. Review and adjust each provider's cost report referred to in section V.A.1 to reflect the result of desk or on-site audits, if available.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

3. Determine total allowable Florida Medicaid cost:
   a. Determine allowable Florida Medicaid property costs, operating costs, direct care costs, indirect care costs, and ROE or use allowance. Direct and indirect care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, except for property costs and ROE or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the ROE cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a ROE for property assets as per sections III.J and K. Beginning with the January 1, 2007 rate period, providers that do not meet the CNA staffing requirements of a minimum 2.7 hours per patient day with a 2.9 hours per patient day weekly average effective January 1, 2007 (hereinafter referred to as the 2007 CNA staffing requirements), based upon the provider's most recent cost report with a fiscal year beginning prior to January 1, 2007, each prospective provider's direct care subcomponent shall be adjusted or grossed up in compliance with the revised staffing requirements. This adjustment will be based on the information provided by each provider in the most recent cost report used to establish the Florida Medicaid per diem rate for the current rate period. The total reported productive hours for CNAs will be
divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for CNA nursing service. Gross up factors will be calculated for CNA hours by dividing the greater of hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by month) into the 2007 CNA staffing requirements. The nursing CNA weighted minimum requirement shall be weighted by days and the 2007 CNA staffing requirements after January 1, 2007, using the time period defined in the cost report used to set the respective rate. Facility direct care CNA costs will be multiplied by the CNA gross up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

b. Effective July 1, 2010 a minimum weekly average of CNA and licensed nursing staffing combined of 3.9 hours of direct care per resident per day is required. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. A minimum CNA staffing of 2.7 hours of direct care per resident per day is required. A facility may not staff below 1 CNA per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day is required. A facility may not staff below 1 licensed nurse per 40 residents. No gross up adjustment will be generated due to the July 1, 2010 staffing revisions because the revisions do not increase the minimum staffing requirements.

c. Effective July 1, 2011 a minimum weekly average of CNA and licensed nursing staffing combined of 3.6 hours of direct care per resident per day is required. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. A
minimum CNA staffing of 2.5 hours of direct care per resident per day is required. A facility may not staff below 1 CNA per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day is required. A facility may not staff below 1 licensed nurse per 40 residents. No gross up adjustment will be generated due to the July 1, 2011 staffing revisions because the revisions do not increase the minimum staffing requirements.

4. Calculate per diems for each of these five cost components listed in section 3.a by dividing the components' costs by the total number of Florida Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per section V.D.

5. Adjust a provider's operating, direct care, and indirect care per diem costs that resulted from section 4 for the effects of inflation by multiplying these per diem costs by the fraction:

\[
\text{Florida Nursing Facility Cost Inflation Index at midpoint of prospective rate period} \div \text{Florida Nursing Facility Cost Inflation Index at midpoint of provider’s cost report period}
\]

The calculation of the Florida Nursing Facility Cost Inflation Index is displayed in Appendix A.

6. The statewide property ceiling for facilities being reimbursed per sections III.G.3 through 5 pending transition to payments based on the FRVS, shall be:
   a. The statewide property cost per diem ceiling is $13.6500.
   b. A provider is subject to a weighted average property ceiling at the addition of beds at 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average rate shall be computed, equal to the sum of:
(1) Actual per diem costs to the provider of the original facility, limited by
the property ceiling $13.6500, multiplied by the ratio of its current beds
to total facility beds; and

(2) Actual per diem costs to the provider of the facility addition, limited by
the property ceiling $18.6230, multiplied by the ratio of its new beds to
total facility beds.

This weighted average rate shall be effective for 18 months from the date the
additional beds were put into service.

7. Determine the median inflated operating, direct care, and indirect care costs per diems for
each of the four classes and for the entire state. For each of the per diems, calculate the
ratios for each of the four class medians to the state medians.

8. Divide individual provider operating, direct care, and indirect care cost per diems that
resulted from section 4 by the ratio calculated for the provider’s facility class in section 7.

9. Determine the statewide median for the per diems obtained in section 8.

10. For each of the operating, direct care, and indirect care per diems, exclude the lower and
upper 10 percent of the per diems of section 8 and calculate the standard deviation for the
remaining 80 percent.

11. Establish the statewide cost-based reimbursement ceiling for the operating cost per diem
as the sum of the median plus one standard deviation and for the direct care and indirect
care cost per diems as the sum of the median plus 1.75 standard deviations that resulted
from sections 9 and 10.

12. Establish the cost-based class reimbursement ceilings for:

a. The operating, direct care, and indirect care costs per diems for classes one
through four as defined in section V.A.2 by multiplying the statewide ceilings in
section 11 by the ratios calculated for that class in section 7.
b. The operating, direct care, and indirect care cost per diems for classes five through six as defined in section V.A.3 as the arithmetic average of the reimbursement ceilings determined in section a.

13. Establish the effective class reimbursement ceilings for operating, direct care, and indirect care cost per diems for each class as the lesser of:
   a. The cost-based class reimbursement ceiling determined in section 12.
   b. The target rate class reimbursement ceiling as calculated in 13.b, from the previous rate period, inflated forward with 1.4 (the class target inflation multiplier) times the rate of increase in the Florida Nursing Facility Cost Inflation Index through a calculation similar to that given in section 14. No reimbursement ceiling can increase in excess of 15 percent annually. The direct care component shall not be limited to the target rate class reimbursement ceiling. The target rate class reimbursement ceiling shall not fall below 90 percent of the cost-based class ceiling for each rate period as calculated in section 12.

14. Establish the provider target reimbursement rate for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost in section 14 from the previous rate period, excluding the MAR, with the quantity:

\[
1 + 2.0 \times \left[ \frac{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the current rate period}} - 1 \right]
\]

In the above calculation the 2.0 shall be referred to as the provider specific target reimbursement rate inflation multiplier. The provider target reimbursement rate limitation shall not fall below 75 percent of the cost-based class reimbursement ceiling.
for each rate setting as calculated in section 12. The direct care component shall not be limited to the target reimbursement rate.

15. Compute the total cost-related per diem for a provider as the sum of:
   a. The lesser of the operating cost per diem obtained in section 5, the provider’s operating provider target rate in section 14, the effective operating class ceiling obtained in section 13, or the provider’s operating new provider target limitation per diem obtained in section I.B.
   b. The lesser of the direct care cost per diem obtained in section 5 or the direct care cost-based class ceiling obtained in section 12.
   c. The lesser of the indirect care cost per diem obtained in section 5, the provider’s indirect care provider target rate in section 14, the indirect care effective class ceiling obtained in section 13, or the provider’s indirect care new provider target limitation per diem obtained in section I.
   d. The lesser of the property cost per diem obtained in section 5 or the applicable statewide property cost per diem ceiling in section 6 for facilities not reimbursed under FRVS. For those reimbursed under FRVS, substitute the FRVS rate calculated per section D, which shall be the sum of the property tax (which excludes sales tax on lease payments), insurance, and home office pass through per diems plus the per diem calculated based on the indexed 80 percent asset value plus the ROE or use allowance per diem calculated on the indexed 20 percent asset value.
   e. ROE per diem obtained in section 4.
   f. The MAR as described in section E.

16. Establish the prospective per diem for a provider as the result of section V.B.

C. Medicaid Trend Adjustment (MTA)

The MTA is a percentage cut that is uniformly applied to all Florida Medicaid providers each rate period which equals all recurring and nonrecurring budget reductions on an annualized basis. The
MTA is applied to all components after targets and ceilings. Below are all the recurring and nonrecurring cuts that are included in the MTA. Please reference Appendix C for each MTA percentage by rate period.

1. Effective July 1, 2005 a recurring annual reduction of $25,853,709 shall be applied proportionally to all rates.

2. Effective January 1, 2008 an additional MTA shall be applied to achieve a recurring annual reduction of $75,182,326.

3. Effective January 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to achieve a reimbursement rate reduction of $83,847,252. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

4. AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

5. Effective March 1, 2009 AHCA shall implement a recurring methodology to reduce individual nursing facility rates proportionately until the $231,362,589 required savings is achieved.

6. Effective July 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to achieve an $81,333,369 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is
necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

7. Effective July 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to maximize the Nursing Facility Quality Assessment (NFQA) fee which will vary based on legislative authority for the assessment, Federal Medical Assistance Percentage (FMAP), and other reductions that have priority. This reduction will only occur if there are sufficient funds collected through the NFQA fee to restore the reduction. Refer to section V.F for a complete description of the methodology used in establishing the NFQA.

8. Effective July 1, 2011 budget authority up to $187,751,660 is provided for modifying the reimbursement for nursing facility rates. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

9. Effective July 1, 2011 AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs. Reimbursement rates shall be as provided in the General Appropriations Act.

10. Effective July 1, 2012 AHCA shall implement a recurring methodology in the Title XIX Long-term Care Reimbursement Plan to reduce nursing facility rates to achieve a $35,160,584 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through
the normal process, prior to including this reduction, if the rate setting unit cost is greater
than the legislative unit cost, then rates shall be reduced by an amount required to achieve
this reduction, but shall not be reduced below the legislative unit cost.

D. Fair Rental Value System (FRVS):

1. FRVS for providers in existing facilities at October 1, 1985:
   a. Each provider in an existing facility at October 1, 1985 shall have an FRVS rate
      established for capitalized tangible assets based upon the assets' acquisition costs
      at the last dates of acquisition prior to July 18, 1984. Facilities purchased after
      July 18, 1984 and not enrolled in the Florida Medicaid program prior to the
      purchase or facilities constructed after July 18, 1984 and enrolled in the
      program, shall have an FRVS rate established on the basis of the last acquisition
      costs prior to enrolling in the Florida Medicaid program. The acquisition costs
      shall be determined from the most current depreciation schedule which shall be
      submitted by each provider. These acquisition costs, including the cost of
      capital improvements and additions subsequent to acquisition, shall be indexed
      forward to October 1, 1985 by a portion of the rate of increase in the Florida
      Construction Cost Inflation (FCCI) Index based on the Dodge Construction
      Index. The change in the FCCI Index from September 1984 to March 1985,
      shall be used to project the FCCI Index for October 1, 1985, with no subsequent
      retroactive adjustment. The costs of land, buildings, equipment, and other
capital items allowable for Florida Medicaid reimbursement per CMS-PUB.15-1,
such as construction loan interest expense capitalized, financing points paid,
attorneys’ fees, and other amortized soft costs associated with financing or
acquisition shall be included in determining allowable acquisition costs subject
to indexing. Property taxes (which exclude sales tax on lease payments) and
property insurance expenses shall not be included in the calculation of the FRVS
rate, but shall be reimbursed prospectively, based on actual costs incurred and
included in the total property rate. For FRVS rates calculated after October 1, 1985, but prior to July 1, 1991, the six month change in the FCCI Index based on the Dodge Construction Index shall be determined for adjusting FRVS rates. For rates effective on or after July 1, 1991, the FCCI Index based on the IHS Healthcare Cost Review quarterly forecast publication, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection shall be used. FRVS rates shall be adjusted for inflation on each rate period, using the change in the FCCI Index for the most recent rate period published prior to the rate period. FRVS rates shall be adjusted per subsections f and i for changes in interest rates on capital debt instruments and for capital additions or improvements on each rate period. See Appendix B for the computation of this index.

b. A single FCCI Index, based upon the average of the Dodge Construction indices for the six cities in Florida for which an index is published, shall be used through June 30, 1991. The most recently published IHS Healthcare Cost Review, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection quarterly indices shall be used for July 1, 1991 and thereafter. The rate of increase in the FCCI Index, for purposes of indexing FRVS rates, shall be limited to a three percent semiannual increase and a six percent annual increase. During rate periods when the increase in the index is greater than the maximum percentage, a credit shall be calculated as the actual increase minus the maximum percentage. This credit shall be carried forward for future periods and added to the increase in the index, up to the maximum percentage, when the actual future increases in the index are less than the maximum percentage. For example, if the increase in the index is four percent in a six-month period, three percent shall be used and a credit of one percent shall be carried forward; then, if the increase in the index is two percent in the
next six-month period, a three percent rate of indexing shall be used, by adding the one percent credit to the actual two percent increase. If more than two percent credits were available, a maximum of three percent rate of indexing would be used, and the remaining credits would again be carried forward to future periods. The credits shall carry forward indefinitely until they are reduced by applying them to periods during which the rate of increase in the FCCI Index is less than the maximum percentage. The credits shall accrue by individual facility, so that any facility entering the program in a period where the increase in the FCCI Index is less than the maximum percentage shall not benefit from credits accrued during prior periods by other facilities.

c. The portion of the FCCI Index increase used to index asset valuation each year shall vary with the number of years the facility participated in the program since January 1, 1972. For the first 10 years of participation, a straight-line increasing portion of the allowable increase in the index shall be used: one-tenth in year one, two-tenths in year two, three-tenths in year three, up to ten-tenths in year 10. The total percent increase allowed for any six-month rate period shall not exceed three percent, shall not exceed four percent for any eight-month period, shall not exceed six percent for any 12-month rate period, and shall not exceed six and a half percent for any 13-month rate period. For the second 10 years, the unadjusted index increase shall be used, subject to a three percent semi-annual limitation and six percent annual limitation. For years 20 through 40, a straight-line decreasing portion of the allowable increase in the index shall be used subject to the three percent limit per six-month rate period, four percent per eight-month period, six percent per 12-month rate period, and six and a half percent per 13-month period: 95 percent in year 21, 90 percent in year 22, 85 percent in year 23, down to 0 percent in year 40. Thus, after 39 years of participation in the program, no further indexing shall be given to a facility.
For rate periods beginning on or after January 1, 1986 an adjustment shall be made in indexing for failure of a licensure re-inspection and for low Florida Medicaid utilization.

(1) Any facility which receives a conditional licensure rating and upon reinspection has not corrected deficiencies as required by AHCA, Bureau of Long Term Care Services, shall receive no indexing in the FRVS rate for the rate period subsequent to the reinspection.

(2) Florida Medicaid utilization shall be calculated as Florida Medicaid patient days divided by total patient days, for fiscal years ending in 1980 or after. The utilization will be calculated from the cost report or budget used to set the rates for the respective rate period. For the initial FRVS rates established on October 1, 1985, cost reports received by AHCA by September 1, 1985, will be used. Years earlier than 1980 shall have no adjustment made for utilization, but rather shall receive full credit for Florida Medicaid utilization. The adjustment for fiscal years ending in 1980 or after shall be computed as follows:

(a) If the provider's cost report or budget shows less than 25 percent average Florida Medicaid utilization for the cost reporting period, then no indexing of asset valuation shall be given.

(b) If 25 percent to 55 percent Florida Medicaid utilization is computed, then the portion of the FCCI Index increase calculated in subsection 1.c shall be multiplied by the fraction equal to the actual utilization percent divided by 55 percent.

(c) If 55 percent or greater Florida Medicaid utilization is computed, then full indexing using the portion of the FCCI Index increase calculated in subsection 1.c shall be given.
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

e. The asset valuation of the facility shall be indexed, according to sections a through d, from the date of entry into the Florida Medicaid program but not prior to January 1, 1972. That asset valuation, subject to the cost per bed ceiling in g., shall be used to initiate the provider’s FRVS property reimbursement at October 1, 1985. The change in the FCCI Index from September 1984 to March 1985 shall be used to project the FCCI Index for October 1, 1985, with no subsequent retroactive adjustment. The total asset valuation shall be divided into two components:

(1) 80 percent of the total asset valuation, which shall be amortized over 20 years at the interest rate specified in section 6 to determine an amount which would pay principal and interest on an installment mortgage for that 80 percent of the asset valuation, and

(2) 20 percent of the asset valuation, which shall be used to calculate a ROE for property-related equity per sections III.J and K. The second component, representing 20 percent of the asset valuation and used as a ROE, will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility or by 75 percent of the maximum annual bed days for providers with newly constructed facilities.

Both components shall be used to calculate per diems which shall be included in the FRVS rate. When calculating the first component, if the provider begins FRVS with a total initial principal balance of all current mortgages less than 60 percent of the indexed asset value, only the interest portion of the calculated installment mortgage on the 80 percent of the asset valuation is used in calculating the provider’s FRVS rate. The calculated first component, based on
either interest plus principal or interest-only expense, will be converted to a per
diem by dividing by 90 percent of the maximum annual bed days of the facility.

However, for providers with newly constructed facilities, the provider’s per
diem calculated for that facility's first year of operation shall be the result of the
principal and interest or interest-only expense divided by 75 percent of the
maximum possible annual bed days. For those providers with facilities that
have put into service new beds for the first 12 months, the provider’s per diem
shall be the result of the principal and interest or interest-only expense divided
by a weighted average occupancy percentage greater than 75 percent but less
than 90 percent of the maximum annual bed days if the addition of beds was 50
percent or more of the existing bed capacity, or the addition of 60 beds or more.

A weighted average occupancy rate shall be computed, equal to the sum of:

<table>
<thead>
<tr>
<th>New Beds</th>
<th>X 75%</th>
<th>Existing Beds prior to the Addition</th>
<th>X 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Facility Beds</td>
<td></td>
<td>Total Facility Beds</td>
<td></td>
</tr>
</tbody>
</table>

For those providers with facilities that have put into service new beds for the
first 12 months, and the addition of beds was 50 percent or more of the existing
bed capacity, or the addition of 60 beds or more, the 20 percent will be
converted to a per diem by dividing by a weighted average occupancy
percentage greater than 75 percent but less than 90 percent of the maximum
annual bed days as outlined in the formulas above.

Property taxes excluding sales tax on lease payments, insurance, and home
office costs shall have a per diem calculated based upon actual historic cost and
patient days as shown in the latest applicable cost report.

f. Mortgages and Interest Rates:
The interest rate used to amortize the 80 percent component of the asset valuation shall be the lower of:

(a) The owner's actual mortgage rate;

(b) The Chase Manhattan Bank's prime rate, hereinafter referenced as Chase prime, as of the date of the provider's loan commitment plus two percent for a variable rate mortgage or plus three percent for a fixed rate mortgage; or

(c) 15 percent.

If an owner has more than one outstanding debt instrument, the owner's actual rate used for this section shall be an average of the rates for all of the outstanding debt, weighted by the amount of the original principal of each debt instrument.

No changes subsequent to establishment of the initial FRVS rate shall be made to the interest rate used to calculate the FRVS rate for providers with fixed rate mortgages except as allowed per (5). For variable rate mortgages, no changes shall be made unless the owner's interest rate changes according to (3).

For the initial FRVS rates at October 1, 1985 the July 1, 1984 Chase prime shall be used for the lesser of comparison with the provider's actual rate. For those providers that received the July 1, 1984 Chase prime (13 percent) at June 30, 1996 beginning with the July 1, 1996 rate period, shall have 12.5 percent used for the lesser of comparison on and after July 1, 1996. For rate periods prior to July 1, 1996, 13 percent shall be used. Providers shall be required to notify AHCA of their mortgage rate and any changes in their mortgage rate. For rate periods prior to September 1, 2015 providers with variable mortgage rates shall submit current changes in their mortgage rates by October 15.
and April 15 of each year to qualify for an adjustment to their FRVS rate on the following January 1 or July 1, respectively. For rate periods beginning on or after September 1, 2015, providers with variable mortgage rates shall submit current changes in their mortgage rates by April 15 of each year to qualify for an adjustment to their FRVS rate on the following September 1. At that time, the FRVS rate to be used for the next rate period shall be determined using the most current mortgage rate, but not to exceed the rate at October 15 or April 15, respectively, Chase prime plus two percent, or 15 percent.

(4) For facilities beginning the FRVS with a total initial principal balance of the mortgages less than 60 percent of their indexed asset value, the interest rate used to amortize the 80 percent component shall be the applicable Chase prime per section (3), but not to exceed 15 percent. The amortization of prime over 20 years shall be used to determine an amount which would pay interest on an installment mortgage for that 80 percent valuation. The prime rate used to initiate FRVS for providers with an initial principal balance of the mortgage less than 60 percent of their indexed asset value shall remain fixed for that provider in calculating future FRVS payments. However, if at some point in the future a provider finances capital assets such that the total original principal of debt instruments equals or exceeds 60 percent of the FRVS asset valuation, then the FRVS rate at the next rate period shall be calculated using the interest rate per section (1).

(5) An increase in the interest rate shall be allowed only if refinancing was necessary in order to finance the addition of new beds, to meet the final payments of the former debt instrument, or to consolidate existing debt excluding debt to owners; for example, in cases where balloon
payments are due. If a new mortgage is secured at the addition of new beds and a prior mortgage is still in effect for the original facility, a weighted average mortgage rate shall be used in section (1) based upon mortgage amounts and interest rates of the various mortgages.

g. The standard, or ceiling, per bed cost shall be established at $28,500 at October 1, 1985. Each existing facility at October 1, 1985 shall have its total capital assets valuation limited to the lesser of that standard or the facility's computed asset valuation, whichever is less. The standard of $28,500 shall be indexed forward every rate period based upon the most recently published increase in the FCCI Index and shall be used to limit new construction costs in the future. New facilities shall be limited to the standard in effect the rate period prior to the date the facility was first put into service as a nursing facility. A facility shall not receive an adjustment to account for increases in the standard at later dates.

h. A hold harmless provision shall be implemented to ensure that facilities existing and enrolled in the Florida Medicaid program at October 1, 1985 do not receive reimbursement for property and ROE or use allowance under the FRVS method less than the property cost reimbursement plus ROE or use allowance given at September 30, 1985. If the FRVS rate would be lower than depreciation plus interest costs under sections III.G.3 through 5, a provider in the facility shall continue to be reimbursed depreciation plus interest according to sections III.G.3 through 5 until such time as the net difference in total payments between sections III.G.3 through 5 and FRVS is zero. Providers who wish to begin FRVS reimbursement that would result in payments less than the depreciation plus interest payments must notify AHCA in writing by December 2, 1985. Providers in facilities with existing leases at October 1, 1985 shall be paid at the September 30, 1985 rate subject to section III.G.2 until the current lease expires, at which time reimbursement shall begin under FRVS based on the owner's

Amendment 2017-011
Effective 07/01/2017
Supersedes 2016-021
Approval 12/12/2017
acquisition costs. Providers shall supply AHCA with the appropriate lessor's ownership costs to receive property reimbursement after the current lease expires. No reimbursement for property-related costs shall be given to a provider in a leased facility subsequent to the expiration of the lease existing at October 1, 1985 if the lessor's ownership costs are not adequately documented per section III.G.4.

i. No adjustments to asset valuation shall be made for replacement of existing equipment. Adjustments at cost shall be allowed for capital improvements and additions. Capital additions of beds shall be subject to the per bed standard as computed in section g that is in effect the rate period prior to the date the facility addition was first put in service as a nursing facility. An adjustment to the FRVS rate may be requested if expenditures for capital additions and improvements totaling $0.40 per available bed day accrue in the cost reporting period utilized in establishing the per diem rate for the upcoming rate period. Costs incurred during a cost reporting period that do not total $0.40 per available bed day shall not be included in the next cost reporting total. Thus, a provider in a 120 bed facility purchasing new equipment which does not replace any old equipment, and making capital improvements at a total unamortized purchase cost less than $17,520 during a twelve-month cost reporting period shall not receive an adjustment to the FRVS rate in the coming rate period or in any rate period for those improvements or equipment. The cost of capital additions or improvements shall be established on the date new beds are put into service, the date of completion for capital improvements, and date of acquisition for equipment or other purchased assets and recognized for FRVS purposes so long as the total indexed asset valuation does not exceed the current per bed standard except as provided below:
(1) In no circumstances, other than (2) and (3) below, shall a provider’s total asset value under FRVS exceed the current per bed standard.

(2) Effective July 1, 1996 providers whose indexed asset valuation exceeds the per bed standard at June 30, 1996 shall be limited to their June 30, 1996 indexed value until the rate period in which their total asset value is less than the current per bed standard.

(3) Providers that entered into a legally enforceable arm’s length agreement prior to July 1, 1996 for the construction or purchase loans of additions (excluding bed additions) or improvements which were not previously reported in a cost report shall have those additions or improvements included in their indexed asset value when the cost report that includes those additions or improvements is used to establish the reimbursement rate. When the above mentioned additions or improvements cause the providers indexed asset value to exceed the current per bed standard, the provider shall be limited to that indexed asset value until the rate period in which that indexed asset value is less than the current per bed standard. Documentation of the legally enforceable, arm’s length agreement must be submitted with the cost report in which the additions or improvements are reported.

(4) Any cost associated with capital additions or improvements, which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate. Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by AHCA.

2. FRVS for providers in facilities entering the Florida Medicaid program subsequent to October 1, 1985:
a. The FRVS rate for providers in facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Florida Medicaid program subsequent to October 1, 1985 shall be calculated as in sections V.D.1.a through g. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under sections III.G.2 through 5.

b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect the rate period prior to the date the facility was first put into service as a nursing facility. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to the rate period prior to the date the facility was first put into service as a nursing facility but not prior to January 1, 1972.

3. Facilities that are currently participating in the Florida Medicaid program but subsequently withdraw:

a. Facilities that participate in the Florida Medicaid program on or after October 1, 1985, but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.

b. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40 year indexing curve per section D.1.c when it withdrew from the program.

4. Property reimbursement for facilities upon change of ownership:

a. Facilities that undergo a change of ownership on or after October 1, 1985 shall be reimbursed for property based upon the provisions contained in this section. It is AHCA's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider.
Therefore, unless stated otherwise in b through f, the new provider's reimbursement shall be based on sections D.1.a through c.

b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of section D.1.h, the new owner shall also receive depreciation plus interest per section III.G unless the new owner requests AHCA, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in section D.1.f.

c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less than 60 percent of the indexed asset value, only the interest portion, at a rate determined in section D.1.f, will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in section D.1.f. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at section D.1.f. Any credits accrued by the previous owner for indexing as described in section D.1.b shall be applied to the new owner.

d. The ROE or use allowance shall be calculated as per section D.1.e. A per diem shall be calculated for property taxes, insurance, and home office costs based upon actual historic cost and patient days shown in the latest applicable cost report, as per section D.1.e.
e. The new provider shall be subject to the recapture provisions in section III.H.
The new provider's cost basis shall be computed per section III.G.3.
f. Reimbursement to a new provider for costs of replacement equipment shall be
governed by the same provisions affecting the previous provider.

5. Capital costs which require Certificate of Need (CON) approval shall be allowed for
reimbursement purposes only if the capital expenditure receives approval from the CON
office. All cost overruns which require CON approval must also be approved in order to
qualify for reimbursement. This section will apply to all providers with Florida Medicaid
certification effective on or after July 1, 1991.

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Facility Cost</td>
<td>$10.0 Million</td>
<td>$9.0 Million</td>
</tr>
<tr>
<td>CON Approval</td>
<td>$7.0 Million</td>
<td>$6.0 Million</td>
</tr>
<tr>
<td>Medicaid Allowable Cost</td>
<td>$6.5 Million</td>
<td>$7.5 Million</td>
</tr>
<tr>
<td>Reimbursable Cost</td>
<td>$6.5 Million</td>
<td>$6.0 Million</td>
</tr>
</tbody>
</table>

Total capital expenditures which are greater than the total amount approved by CON
shall not be recognized for reimbursement purposes. In the example above, the
reimbursable cost, which is considered in rate calculations, is the lower of the new
facility cost, CON approval, or the Florida Medicaid allowable cost.

E. Medicaid Adjustment Rate (MAR)
The MAR for direct care and indirect care shall be calculated as follows:

1. Facilities with 90 percent or greater Florida Medicaid utilization shall have their MAR
equal their WBR as determined in section E.3.

2. Facilities with 50 percent or less Medicaid utilization shall receive no MAR.

3. Facilities between 50 percent and 90 percent Medicaid utilization shall have their MAR
as determined by the following formula:
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

**MAR** = **WBR** X **MA**

\[
WBR = \left( BR \times MAW \right) \times \frac{(Superior + Standard)}{All}
\]

**MA** = \((Medicaid Utilization \% - MIN) \div (MAX - MIN)\)

Definitions:

- **MAR** - Medicaid Adjustment Rate
- **WBR** - Weighted Base Rate
- **MA** - Medicaid Adjustment
- **BR** - Base Rate, which is set as the result of sections V.B.15.b and c.
- **MAW** - Medicaid Adjustment Weight, which is set at .045
- **Superior** - Number of Superior Days as described in 4.
- **Standard** - Number of Standard Days as described in 4.
- **All** - All superior, standard, and conditional days
- **MIN** - Minimum Medicaid utilization amount which is set at 50 percent
- **MAX** - Maximum Florida Medicaid utilization amount which is set at 90 percent

4. Determine the number of days one year prior to the rate period for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

Example - For the rate period January 1, 2014 through June 30, 2014, the period one year prior is January 1, 2013 to June 30, 2013. During that prior period, the provider's licensure ratings were:
The result of these calculations will represent the MAR to which the provider is entitled. This rate is to be included in the direct care and indirect care component of the provider's total reimbursement rate.

5. Only providers being paid a prospective rate under section V.B.6 shall be eligible for the MAR.

F. Nursing Facility Quality Assessment (NFQA)

Effective April 1, 2009, AHCA, in accordance with section 409.9082, F.S., shall implement methodologies revising reimbursement to nursing facilities that will create a pass-through of the Florida Medicaid share of the assessment, restore prior reductions as allowed, and provide for an operating add-on as a phase-in to a pricing model. The funding for reimbursement improvements is provided through the NFQA fee. The funds shall exclusively be for the following purposes and in the following order of priority:

1. To reimburse the Florida Medicaid share of the NFQA fee as a pass through. The per diem Florida Medicaid share of the NFQA is calculated as follows:
   a. Total patient days minus Medicare days is equal to total non-Medicare days.
   b. The product of total non-Medicare days, NFQA rate and Florida Medicaid utilization to is equal to the total NFQA Florida Medicaid share.
   c. Total NFQA Florida Medicaid share divided by Florida Medicaid days is equal to the per diem Florida Medicaid Share of the NFQA.
2. To increase each nursing facility’s Florida Medicaid rate, an amount that restores the rate reductions effective on or after January 1, 2008. These reductions are listed in sections V.C.2 through 10.

3. To increase each nursing facility’s Florida Medicaid rate that accounts for the remainder of the total assessment not included in sections V.F.1 through 2. The rate increase is a pass though which is calculated by taking total funds remaining after sections V.F.1 through 2. Then, subtract budgeted administrative cost and funds required for Hospice rate cut restoration to equal total quality assessment funds remaining. Next, divide total quality assessment funds remaining by annualized Florida Medicaid days to determine the increase available for nursing facilities’ Florida Medicaid rates.

Each facility shall report monthly to AHCA its total number of resident days, exclusive of Medicare resident days, and remit an amount equal to the assessment rate times the reported number of days. Facilities are required to submit their assessment by the 20th day of the next succeeding calendar month.

VI. Prospective Payment System

Effective October 1, 2018 a prospective payment methodology shall be implemented for rate setting purposes. The following outlines the requirements to transition to a prospective payment system.

A. Exempt Facilities

1. Pediatric, Florida Department of Veterans Affairs, and government-operated facilities are exempt from reimbursement under the prospective payment methodology. These providers shall be reimbursed on a cost-based prospective payment system.

   a. Facilities that have both licensed pediatric beds and community or sheltered beds must file two separate cost reports in accordance with Sections I and III in order to separate the cost of care associated with the Pediatric population. The cost reports must use cost allocation methodologies in accordance with CMS.

   PUB.15-1.

B. Quality Incentive Component
The prospective payment system will include a quality incentive add-on component consisting of process, outcome, structural, and credentialing measures.

1. Process Measures
   For each process measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the process measures will be calculated using the most recent one-year average from the Minimum Data Set (MDS) Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.
   a. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
   b. Percentage of long-stay residents who received an antipsychotic medication
   c. Percentage of long-stay residents who were physically restrained

2. Outcome Measures
   For each outcome measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the outcome measures will be calculated using the most recent one-year average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.
   a. Percentage of long-stay residents with a urinary tract infection
   b. Percentage of high-risk long-stay residents with pressure ulcers
   c. Percentage of long-stay residents experiencing one or more falls with major injury
d. Percentage of low-risk long-stay residents who lose control of their bowels or bladder

e. Percentage of long-stay residents whose need for help with daily activities has increased

3. Structural Measures

For each structural measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology.

a. Hours of licensed nursing (RN, LPN) and CNA staffing

The licensed nursing and CNA staffing measure will be calculated using the total combined RN, LPN, and CNA productive hours per patient day as reported in the Medicaid cost report submitted prior to the cost report cutoff date. For a new provider with no cost history resulting from a change of ownership or operator, the measure will be calculated using the prior provider’s cost report submitted prior to the cost report cutoff date.

b. Social work and activities staffing

The social work and activities staffing measure will be calculated using the total number of qualified activities professionals and qualified social workers employed by the facility on a full-time basis, part-time basis, or under contract to a facility per resident day. For each rate period, the data will be collected from the CMS-671 and CMS-672 reports as of May 31 of the year in which the rate period begins.

4. Credential Measures

a. CMS 5 Star Rating

For each rate period, the CMS 5 Star Rating Measure will be calculated using the most recent overall rating from the Star Ratings dataset from the Nursing
Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

b. Nursing Home Gold Seal Award

For each rate period, the Nursing Home Gold Seal Award measure will be calculated using the licensees with the Gold Seal designation as of May 31 of the year in which the rate period begins.

c. Joint Commission Accreditation

For each rate period, the Joint Commission Accreditation measure will be calculated using the providers with accreditation as of May 31 of the year in which the rate period begins.

d. AHCA National Quality Award

For each rate period, the AHCA National Quality Award measure will be calculated using the gold or silver level award recipients as of May 31 of the year in which the rate period begins.

C. Fair Rental Value System (FRVS)

1. A FRVS will be implemented to reimburse providers for their facility-related property and capital costs. Each provider participating in the Florida Medicaid program shall submit a fair rental value survey using the electronic form and instructions on the Florida Nursing Home: Fair Rental Value Survey web page. The most recent FRVS survey received by April 30 of the year in which the rate period begins will be used to calculate the FRVS rate. Extensions will not be granted.

2. If a facility fails to submit an FRVS survey by April 30, 2018, no building additions, replacements, renovation, or major improvement data will be used in the FRVS calculation for the October 1, 2018 rate semester. In addition, for a provider who has never submitted an FRVS survey to the Agency, the FRVS calculation will use the minimum square footage as the facility square footage.
3. The Agency may perform desk reviews on the provider-submitted survey data and amend the survey data based on the desk review results.

D. Transition

Beginning October 1, 2018, the Agency shall reimburse providers the greater of their cost-based rate effective September 1, 2016, hereinafter referred to as “hold harmless rate”, or their prospective payment rate.

1. The hold harmless rate will be the most current rate published to the Agency’s web page with a September 1, 2016 effective date on May 31, 2018.

2. For providers with no published rate effective September 1, 2016, the hold harmless rate will be the prior provider’s most current rate published to the Agency’s web page with a September 1, 2016 effective date on May 31, 2018.

3. New facilities that began operation after September 1, 2016 will not qualify for the transition payment and will receive their prospective payment rate.

VII. Payment Assurance

The State shall pay each nursing facility for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59G-6.010, F.A.C., 42 CFR, and section 1902 of the SSA. The payment amount shall be determined for each nursing facility according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VIII. Provider Participation

This Plan is designed to assure adequate participation of nursing facilities in the Florida Medicaid program and the availability of high quality nursing facility services for recipients which are comparable to those available to the general public.

IX. Payment in Full

Any provider participating in the Florida Medicaid program who knowingly and willfully charges money or other consideration, for any service provided to the patient under the state plan in excess of the rates established by the State Plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise
required to be paid under the State Plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility, or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State Plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15.

X. Glossary

A. Acceptable cost report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. AHCA - Agency for Health Care Administration.

C. Audit - A direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

D. Audit adjustment - Any adjustment within the Florida Medicaid audit report or Florida Medicaid desk review report on Attachment A.

E. Audit finding - Any adjustment within the Florida Medicaid audit report or Florida Medicaid desk review report not listed on Attachment A.

F. Bed - A licensed Skilled Nursing Facility (SNF) bed.


H. Rate setting acceptance cut-off date - The rate setting acceptance cut-off date is April 30 or the next business day if April 30 falls on a weekend.

I. Cost report due date - A provider’s cost report is due five calendar months after the close of the provider’s cost reporting year. Initial cost reports are due 23 months after the Florida Medicaid provider’s effective date.
J. Desk review - An examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from AHCA reviewer’s office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

K. Facility - The physical grounds and buildings where a provider operates a licensed nursing facility.

L. Government-operated facility – A nursing facility operated by a city, county, state, or federal government entity, including hospital districts owned by city or county government entities.

M. Late cost report - A cost report that is not received by AHCA on the cost report due date.

N. Legislative unit cost - The weighted average per diem of the state anticipated expenditure after all rate reductions.

O. Medicaid Adjustment Rate (MAR) - An add-on to the direct care and indirect care cost components of providers with greater than 50 percent Florida Medicaid utilization to encourage high quality care while containing costs. The MAR per diem calculation is detailed in section V.E of this Plan.

P. Medicaid interim reimbursement rate - A component of an overall reimbursement rate that is calculated from budgeted cost data. Any overpayments or under payments resulting from the difference between budgeted cost rates and actual cost rates (limited by provider specific targets and class or statewide ceilings), as determined through an audit of the same reporting period, will be either refunded to AHCA or paid to the provider as appropriate.

Q. Medicaid nursing facility direct and indirect patient care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

R. Medicaid nursing facility operating costs - Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. ROE or use allowance costs are not included in operating costs.

S. Medicaid nursing facility property costs - Those costs related to the ownership or leasing of a nursing facility. Such costs may include property taxes, insurance, interest and depreciation, or rent.
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

T. Provider - A person or entity licensed and/or certified under state law to deliver health care or related services, which services are reimbursable under the Florida Medicaid program.

U. Rate period - September 1 - August 31 between September 1, 2015 and August 31, 2017.

V. Rate setting unit cost - The weighted average per diem after all rate reductions based on submitted cost reports.

W. Region - AHCA shall plan and administer its programs of health, social, and rehabilitative services through 11 service areas composed of the following counties:
   1. Region 1 - Escambia, Okaloosa, Santa Rosa, and Walton counties
   2. Region 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington counties
   3. Region 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwanee, and Union counties
   4. Region 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties
   5. Region 5 - Pasco and Pinellas counties
   6. Region 6 - Hardee, Highlands, Hillsborough, Manatee, and Polk counties
   7. Region 7 - Brevard, Orange, Osceola, and Seminole counties
   8. Region 8 - Charlotte, Collier, Desoto, Glades, Hendry, Lee, and Sarasota counties
   9. Region 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
  10. Region 10 - Broward county
  11. Region 11 - Dade and Monroe counties

X. Reimbursement ceilings - The upper rate limits for a Florida Medicaid nursing facility’s operating and patient care reimbursement for nursing facilities in a specified reimbursement class or the upper limit for a nursing facility’s property cost reimbursement for all nursing facilities statewide.

Z. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare, as provided for in the SSA, as certified by 42, United States Code (U.S.C.) (1395-1395pp).

AA. Title XIX - Grants to States for Medical Assistance Programs (Medicaid, as provided for in the SSA, as certified by 42, U.S.C. 1396-1396i).
Appendix A: Calculation of Florida Nursing Facility Cost Inflation Index

The following example uses data from the September 1, 2015 rate period. For this rate period the percentage weights for the cost components are:

<table>
<thead>
<tr>
<th>Component</th>
<th>Direct Patient Care</th>
<th>Indirect Patient Care</th>
<th>Operating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>100.0%</td>
<td>55.75%</td>
<td>55.75%</td>
</tr>
<tr>
<td>Dietary</td>
<td>0.0%</td>
<td>6.23%</td>
<td>6.23%</td>
</tr>
<tr>
<td>Others</td>
<td>0.0%</td>
<td>38.02%</td>
<td>38.02%</td>
</tr>
</tbody>
</table>

An inflation index for each of these components is developed from IHS Healthcare Cost Review quarterly index, Skilled Nursing Facility without Capital Market Basket table, using the following routine services costs inflation indices:

<table>
<thead>
<tr>
<th>Component</th>
<th>IHS Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>Wage &amp; Salary combined with Employee Benefits</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others</td>
<td>Utilities combined with All Other Expenses</td>
</tr>
</tbody>
</table>

The IHS indices are combined by summing the products of each index times the ratio of the respective Global Insight budget share to total budget share represented by the combined indices.

The following example uses data from the first quarter of 2015 Healthcare Cost Review publication to calculate the first quarter of 2014 Salaries and Benefits component. The All Others Index is calculated in the same manner.
The Weighted Salaries and Benefits index is calculated using the following formula:

\[ \frac{(1.220 \times 0.519)/(0.519+0.118)) + (1.245 \times 0.118/(0.519+0.118)) = 1.225 }{ } \]

A Combined Quarterly Index is then constructed by summing the products of the weights and quarterly component indices.

The Combined Quarterly Index is calculated using the following formula:

\[ \text{(Weighted Salaries & Benefits Index X percentage weight) + (Dietary Index X percentage weight)} \]
\[ + \text{(Weighted All Others Index X percentage weight)} \]

\[ (1.225 \times 55.75\%) + (1.360 \times 6.23\%) + (1.483 \times 38.02\%) = 1.33149863 \]

The Weighted Salaries and Benefits Index and the Combined Quarterly Index is utilized to obtain monthly indices called the Florida Nursing Facility Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

The Average Weighted Salaries & Benefits Index for months with end dates that correspond with the end date of a quarter is calculated using the following formula. The Average Combined Quarterly Index is calculated in the same manner for these months.

Average Weighted Salaries & Benefits Index = [(Weighted Salary & Benefits Index for current quarter + Weighted Salary & Benefits Index for following quarter) / 2]

### Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

#### Amendment 2017-011
Effective 07/01/2017
Supersedes 2016-021
Approval 12/12/2017

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Average Weighted Salaries &amp; Benefits Index</th>
<th>Average Combined Quarterly Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014:1</td>
<td>1.226</td>
<td>1.334</td>
<td>March 31</td>
</tr>
<tr>
<td>2014:2</td>
<td>1.229</td>
<td>1.342</td>
<td>June 30</td>
</tr>
<tr>
<td>2014:3</td>
<td>1.235</td>
<td>1.350</td>
<td>September 30</td>
</tr>
<tr>
<td>2014:4</td>
<td>1.244</td>
<td>1.361</td>
<td>December 31</td>
</tr>
</tbody>
</table>

The Average Weighted Salaries & Benefits Index and Average Combined Quarterly Index for months that do not end on the end date of a quarter are calculated as follows:

April 2014 Average Weighted Salaries & Benefits Index

\[ = \left( \frac{\text{June 30 Index}}{\text{March 31 Index}} \right)^{1/3} \times \text{March 31 Index} \]

\[ = \left( \frac{1.229}{1.226} \right)^{1/3} \times 1.226 = 1.227 \]

May 2014 Direct Care Inflation Index

\[ = \left( \frac{\text{June 30 Index}}{\text{March 31 Index}} \right)^{2/3} \times \text{March 31 Index} \]

\[ = \left( \frac{1.342}{1.334} \right)^{2/3} \times 1.334 = 1.339 \]

These indices will be updated prior to each rate setting.
Appendix B: Calculation of the Florida Construction Cost Inflation Index

For Rates Effective on and after 7/1/1991

The Florida Construction Cost Inflation Index is calculated from IHS Healthcare Cost Review quarterly forecast publication, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection. The Florida Index is calculated by the following steps:

1. Using the most recent publication, locate the tables containing the Consumer Price Index All Items.

2. Using the South Region, divide the index corresponding to the midpoint of the current rate period by the index of the midpoint of the previous rate period. The results shall be the inflation multiplier for the rate period.

Example - Rate Period – July 2014

Publication - IHS Healthcare Cost Review, First Quarter 2014, Table 7.

<table>
<thead>
<tr>
<th>Corresponding Quarter</th>
<th>Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014:4</td>
<td>233.6</td>
<td>233.000</td>
<td>September 30</td>
</tr>
<tr>
<td>2014:3</td>
<td>232.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014:2</td>
<td>230.8</td>
<td>230.150</td>
<td>March 31</td>
</tr>
<tr>
<td>2014:1</td>
<td>229.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The six month inflation multiplier is calculated by:

\[
\frac{233.000}{230.150} = 1.012383 \text{ or } 1.2383 \text{ percent increase over 6 months}
\]

These indices will be updated prior to each rate period using the current data.
**Appendix C: Florida Medicaid Trend Adjustment (MTA) Percentages**

The following are the uniform percentage cuts for the effective rate period listed.

<table>
<thead>
<tr>
<th>Rate Period</th>
<th>Uniform Medicaid Trend Adjustment</th>
<th>Annualized Reduction Amount</th>
<th>Uniform Medicaid Trend Adjustment with NFQA effect</th>
<th>Annualized Reduction Amount with NFQA effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/05</td>
<td>0.40%</td>
<td>$25,853,709</td>
<td>0.40%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/06</td>
<td>1.48%</td>
<td>$25,853,709</td>
<td>1.48%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/06</td>
<td>0.96%</td>
<td>$25,853,709</td>
<td>0.96%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/07</td>
<td>0.93%</td>
<td>$25,853,709</td>
<td>0.93%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/07</td>
<td>0.91%</td>
<td>$25,853,709</td>
<td>0.91%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/08</td>
<td>3.52%</td>
<td>$101,036,035</td>
<td>3.52%</td>
<td>$101,036,035</td>
</tr>
<tr>
<td>7/08</td>
<td>3.52%</td>
<td>$101,036,035</td>
<td>3.52%</td>
<td>$101,036,035</td>
</tr>
<tr>
<td>1/09</td>
<td>6.28%</td>
<td>$184,883,287</td>
<td>6.28%</td>
<td>$184,883,287</td>
</tr>
<tr>
<td>4/09</td>
<td>14.13%</td>
<td>$416,245,876</td>
<td>0.88%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/09</td>
<td>21.42%</td>
<td>$621,282,257</td>
<td>0.89%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/10</td>
<td>21.36%</td>
<td>$621,282,257</td>
<td>0.89%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/10</td>
<td>23.52%</td>
<td>$644,823,648</td>
<td>0.87%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/11</td>
<td>23.52%</td>
<td>$644,823,648</td>
<td>0.87%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/11</td>
<td>22.75%</td>
<td>$685,330,905</td>
<td>7.30%</td>
<td>$220,042,943</td>
</tr>
<tr>
<td>1/12</td>
<td>22.63%</td>
<td>$685,330,905</td>
<td>7.25%</td>
<td>$219,612,898</td>
</tr>
<tr>
<td>7/12</td>
<td>23.58%</td>
<td>$720,491,489</td>
<td>5.19%</td>
<td>$180,411,212</td>
</tr>
<tr>
<td>1/13</td>
<td>23.29%</td>
<td>$720,491,489</td>
<td>5.83%</td>
<td>$180,411,212</td>
</tr>
<tr>
<td>7/13</td>
<td>23.18%</td>
<td>$720,491,489</td>
<td>4.34%</td>
<td>$135,121,640</td>
</tr>
<tr>
<td>1/14</td>
<td>22.94%</td>
<td>$720,491,489</td>
<td>4.30%</td>
<td>$135,121,640</td>
</tr>
<tr>
<td>7/14</td>
<td>22.85%</td>
<td>$720,491,489</td>
<td>1.78%</td>
<td>$55,972,168</td>
</tr>
<tr>
<td>1/15</td>
<td>22.39%</td>
<td>$720,491,489</td>
<td>1.74%</td>
<td>$55,972,168</td>
</tr>
<tr>
<td>9/15</td>
<td>22.03%</td>
<td>$727,085,771</td>
<td>3.42%</td>
<td>$113,042,327</td>
</tr>
<tr>
<td>9/16</td>
<td>23.30%</td>
<td>$785,809,410</td>
<td>4.54%</td>
<td>$153,025,001</td>
</tr>
<tr>
<td>9/17</td>
<td>25.01%</td>
<td>$866,210,819</td>
<td>5.76%</td>
<td>$199,525,429</td>
</tr>
</tbody>
</table>

Note: Effective April 1, 2009 the Nursing Facility Quality Assessment (NFQA) fee, as referenced in section V.F of this Plan, was implemented for the purpose of restoring the annualized recurring reductions implemented on or after January 1, 2008. Effective September 1, 2015 a cut to reduce the unit cost was required in accordance with section V.C.9.
Appendix D: Upper Payment Limit (UPL) Methodology

A. Pursuant to 42 CFR 447.272, AHCA shall use a cost-based demonstration to ensure Florida Medicaid expenditures do not exceed the Upper Payment Limit (UPL), a reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles. The UPL shall be determined separately for state government, non-state government, and privately owned or operated nursing facilities. The UPL calculation requires the compilation of Medicare and Florida Medicaid data for all nursing facilities that participate in the Florida Medicaid program. Medicare data shall be acquired from the most recently available, filed Medicare cost report, Form #CMS 2540, from a reporting period no more than two years prior to the current rate year. The following fields from the Medicare cost report are used in the UPL calculation:

1. Total Medicare Routine Cost found on Worksheet B or Worksheet D.
2. Ancillary Medicare Charges, Ancillary Medicare Cost, Drug Charges, and Drug Cost found on Worksheet C.
3. Medicare Days found on Worksheet D or Worksheet S.

B. Florida Medicaid charges and days reported in the Florida Medicaid cost reports, which are used for the September 1, 2017 rate setting, shall be used for the fiscal year 2017-2018 UPL calculation. The state shall only include Florida Medicaid charges from in-state Florida Medicaid residents and shall exclude crossover claims, physician service charges, and other professional service charges. Estimated Florida Medicaid expenditures for the applicable fiscal year shall be calculated based on the nursing facility per diem rates effective September 1, 2016 and September 1, 2017. The average of the rates will be multiplied by annualized Florida Medicaid days to determine total estimated Florida Medicaid expenditures. The Florida Medicaid expenditures shall be the net actual total expenditures excluding patient responsibility. The Florida Medicaid expenditures include base payments through Florida Medicaid reimbursement to the provider. Payments shall be identified separately as private, state government, and non-state government. The dollar amount of payments for the UPL base period shall equal the claimed amounts on the CMS-64, a quarterly expense report.
C. The total UPL for each provider shall be trended from the midpoint of the corresponding Medicare cost report to the midpoint of the state fiscal year. The data shall be trended to inflate historical Medicare costs to reflect current period expenses. The trending factors shall come from the IHS Healthcare Cost Review, the Skilled Nursing Facility Total Market Basket Index, and the %MOVAVG line.

D. The Total Trended Upper Payment Limit shall be calculated for each facility as follows:

\[
\text{Total Trended Upper Payment Limit} = \text{Total Upper Payment Limit} \times \text{Trend Factor}
\]

\[
\text{Total Upper Payment Limit} = \text{Routine UPL Cost} + \text{Ancillary UPL Cost}
\]

\[
\text{Routine UPL Cost} = \frac{\text{Total Medicare Routine Cost}}{\text{Medicare Days}} \times \text{Annualized Florida Medicaid Days}
\]

\[
\text{Ancillary UPL Cost} = \frac{(\text{Ancillary Medicare Cost} - \text{Medicare Drug Cost})}{(\text{Ancillary Medicare Charges} - \text{Medicare Drug Charges})} \times \text{Ancillary Florida Medicaid Charges}
\]

Note: The Ancillary UPL Cost shall be calculated by removing costs and charges for drugs to account for differences in Medicare and Florida Medicaid costs and charges.
I. Cost Finding and Cost Reporting

A. Each intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR-DD) provider participating in the Florida Medicaid program shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time up to six months from fiscal year end for filing cost reports. An extension for filing a cost report is not an exception to the February 1, and August 1 dates in determining which cost reports are used to establish rates effective April 1 and October 1 of each year. The cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII cost reporting, if applicable. Four complete, legible copies of the cost report shall be submitted to the Agency for Health Care Administration.

B. Cost reports used to establish rates effective April 1, 1991 shall be used to establish rates effective July 1, 1991 for all providers enrolled in the Medicaid program as of April 1, 1991.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report must be prepared using the accrual basis of...
accounting in accordance with generally accepted accounting principles, as incorporated by reference in Rule 61H1-20.007 F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual CMS PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities, and State of Florida Administrative Rules. The CMS PUB.15-1 Manual may be obtained from the regional Health Care Financing Administration office in Atlanta. For government-owned and operated facilities operating on a cash method of accounting, data based on such a method of accounting will be acceptable. The person preparing the cost report must sign the cost report as the preparer. Cost reports which are not signed shall not be accepted.

D. If a provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 90 days, then the provider’s rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. A provider who does not file within 180 days of the end of his cost reporting period shall have his contract canceled.

E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership must file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with Title 42 Code of Federal Regulations (CFR), Sections 413.24 (a),(b),(c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information must be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all
ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and must be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records must be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 3 years following the date of submission of the cost report form to AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 must be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I. New providers entering the program must submit a cost report for a period of not less than 12 months for purposes of setting prospective rates. A partial-year cost report may be submitted initially, but may be used only to adjust the interim budgeted rate in effect.

J. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."
II. Audits

All cost reports submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits and desk audits of cost reports and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor must express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, Florida Statutes.

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for such.

III. Allowable Costs
A. The cost report must include all items of expense which a provider must incur in meeting:

1. The definition of intermediate care facility set forth in Section 42 CFR 440.150;
2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act in 42 CFR 442, Subpart C;
3. The requirements established by the state agency responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610; and
4. Any other requirements for licensing under laws in the state which are necessary for providing long-term care facility services, as applicable.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative or other professional treatments which shall be composed of, for example, medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy or other mental retardation specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII principles of reimbursement, CMS PUB.15-1 (1993), and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses for services covered by Florida Medicaid programs other than the ICF/MR-DD Program are not allowable
under this plan and should not be included in the ICF/MR-DD cost report for Medicaid. These include expenses associated with prescription drugs, physicians’ fees, etc. Refer to the services covered by the Medicaid ICF/MR-DD vendor payment in the Florida Medicaid ICF/MR-DD Services Coverage and Limitations Handbook. Refer to Chapter 59G-4.170, F.A.C., for further clarification of allowable and non-allowable costs.

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients’ responsibilities. Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay $10.00. If Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt. Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17 Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS PUB.15-1. Providers must identify such related organizations and costs in their cost reports.

G. Other costs which are allowable shall be limited by the following provisions:

1. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 (1993) or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:

   a. It is the intent of the Medicaid program to limit lease cost reimbursement, that is, rent, to the allowable ownership costs associated with the leased land, building, and equipment. For the
purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:

(1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;

(2) Sales tax on lease payments, if applicable; and

(3) Return on equity that would be paid to the owner if he were the provider, as per Section H. below.

b. Implementation of this provision shall be in accordance with the following:

(1) Reimbursable lease costs of existing providers as of July 18, 1984 will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement commencing on or after July 18, 1984 with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in
property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record as of July 18, 1984 or the rent, whichever is lower.

(3) For new providers entering the Medicaid program on or after July 18, 1984, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs must be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner must also state that the owner agrees to make his books and records of original entry related to the ICF/MR-DD properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in Section III.G.3. below.
(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (4) above.

3. Basis for depreciation and calculation:
   
a. Cost.
   
   Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of b. below. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 (1993) will be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with Section 1902(a)(13)(c) of the Social Security Act, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for the mentally retarded and developmentally disabled shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

(1) One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated
retrospectively by the Secretary of H.H.S.) in the current Dodge Construction Systems Cost for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(2) One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

In any change in ownership, the total valuation of capital assets allowed for determining payment rates shall not exceed the lessor of:

(1) The acquisition cost of the facility to the new owner; or

(2) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital indebtedness, and, if applicable, return on equity.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new owner purchases the facility in 1990 for $700,000. The increase in the Dodge Construction Index and the Consumer Price Index from the date of acquisition by the seller to the date of change in ownership is 25% and 20% respectively. The new owner’s allowable depreciable basis is $550,000.

Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner’s allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of
Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(1) The gross recapture amount shall be the lesser of the actual gain on the sale or the Medicaid portion of accumulated depreciation after the effective date of January 1, 1972.

The gross recapture amount shall be reduced by .877193 percent for each month in excess of forty-eight (48) months participation in the Medicaid program. Additional beds and other related depreciable assets put into service after July 1, 1990 shall be subject to the same thirteen and one-half (13 1/2) year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of forty-eight (48) months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:
Sales Price: $6,000,000

Older Portion of Facility:
Number of beds = 60

Newer portion of facility:
Number of beds = 120

Allocation to older portion: \( \left( \frac{60}{180} \right) \times 6,000,000 = 2,000,000 \)

Allocation to new portion: \( \left( \frac{120}{180} \right) \times 6,000,000 = 4,000,000 \)

Sale Price \( = 6,000,000 \)

(2) The adjusted gross recapture amounts as determined in (1) above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in (2) above shall be paid by the former owners, to the State. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Medicaid program.
In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the same time he was the Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another, unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. In addition, if an owner-operator elects to withdraw from the Medicaid program and lease the facility to an operator who continues to participate in the Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, Section III.G.3.c, at the time the facility is sold. On or after July 1, 1984, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the department creating an equitable lien on the owner’s capital assets. This lien shall be filed by the department with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the agency upon sale of the facility. In the event that a provider fails to sign and return the contract to the department, the Proof of Financial Ability which is required for the prospective operator of the facility to be licensed shall not be approved.
(2) For lessees entering the Medicaid program after July 1, 1984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July 1, 1984, the portion of the Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the months that he was the Medicaid provider or a lessor to a Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's
allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on return on equity ROE. Return on equity is also limited by the new owner's allowed acquisition cost. The new owner can receive a return on equity based upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per CMS PUB.15-1 (1993) provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993), and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.
7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Use Allowance

A use allowance shall not be paid for publicly owned and publicly operated facilities.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if
requested, shall be held so that interested members of the public shall be afforded
the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual
provider based on the most recent historic costs. If certain costs are determined by
the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the
Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993) and this Plan, to
exceed the level that a prudent buyer would incur, then the excess costs shall not
be reimbursable under the plan.

C. Prospective payment rates shall be established semi-annually on April 1 and
October 1. The most current acceptable cost report received by the agency by
February 1 and August 1 shall be used in the rate-setting process to set rates
effective on April 1 and October 1, respectively. The rate-setting process is
detailed in Section V of this plan. The same cost reports used for the April 1,
1991 rate semester shall be used to establish rates effective July 1, 1991 through
March 31, 1992. There shall not be a rate semester for October 1, 1991.

D. Reimbursement rates shall be calculated separately for two classes. The classes
shall be based on the four levels of ICF/MR-DD care as defined in Chapter 59G-
4.170 of the Florida Administrative Code. The four levels of care, listed in
ascending order of handicap severity, are Developmental Residential,
Developmental Institutional, Developmental Non-ambulatory, and Developmental
Medical. Developmental Residential and Developmental Institutional shall
constitute one class for reimbursement purposes, while Developmental Non-
ambulatory and Developmental Medical shall constitute the other. All providers
must allocate costs by the four levels of care in their cost reports. The agency
shall monitor placements of clients to determine whether discrimination against
clients with higher cost or more complex service needs is occurring. If the agency
determines that such placement discrimination is occurring, this plan may be
amended to provide for payments based on four levels of care.
E. For the two classes described in D. above, three components of the total reimbursement rate shall be calculated separately. These three components are operating costs, resident care costs, property costs. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.
2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (1), (2), and (3) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in
effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:
Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

I. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12-month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid and the Developmental Services Program Office.

J. Base Costs:
The initial base costs for each provider shall be allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Medicaid program the initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unadited costs shall be retroactively adjusted when audit results become available.

K. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(6), the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement.
At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, property cost shall be reduced or eliminated as necessary to meet the aggregate test.

V. Methodology

A. Prospective rate-setting method for rate semesters beginning on or after July 1, 1991.

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester July 1, 1991 through March 31, 1992, the same cost reports used in setting April 1, 1991, rates shall be used. There shall not be a rate semester for October 1, 1991.

2. Review and adjust the provider's current cost report on file to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, and operating cost. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A.

4. Calculate per diems for each of the three cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. The new base per diem for property shall be the per diem established in step 4 above.
6. Using the appropriate current per diem for resident care and operating costs from Step 4 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:
   Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992.

7. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step 6 plus the current approved per diem for property, from Step 5.

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities.

VII. Provider Participation

This plan is designed to assure adequate participation of Publicly Owned and Publicly Operated ICF/MR-DD providers in the Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or
charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to a Publicly Owned and Publicly Operated ICF/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15.

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

CMS PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

DCF: Department of Children and Family Services

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.
APPENDIX A

Provider Number

Provider Name

Address

<table>
<thead>
<tr>
<th>COL C</th>
<th>COL A</th>
<th>COL B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resid./</td>
<td>Non-amb./</td>
</tr>
<tr>
<td></td>
<td>Inst.</td>
<td>Medical</td>
</tr>
</tbody>
</table>

A. Alloc of Exp (Excl B&C)

1. Resident Days
   - COL A: 02461
   - COL B: 8325
   - TOTAL: 10786

2. OPER. EXPENSE COMP
   a. Administration
   - COL A: 
   - COL B: 
   - TOTAL: 120482
   b. Plant Operation
   - COL A: 
   - COL B: 
   - TOTAL: 45060
   c. Laundry
   - COL A: 
   - COL B: 
   - TOTAL: 15265
   d. Housekeeping
   - COL A: 
   - COL B: 
   - TOTAL: 29090
   e. Oper. Exp. Comp and Per Diem
   - COL A: 19.460
   - COL B: 19.460
   - TOTAL: 209897

3. Resident Care Expense
   a. Dietary
   - COL A: 
   - COL B: 
   - TOTAL: 74861
   b. Other
   - COL A: 
   - COL B: 34188
   c. Nursing
   - COL A: 
   - COL B: 
   - TOTAL: 86018
   d. Res. Care Exp. and Per Diem
   - COL A: 18.0852
   - COL B: 18.0852
   - TOTAL: 19.5067

4. PROP. EXP. COMP. AND PER DIEM
   - COL A: 8.605
   - COL B: 8.605
   - TOTAL: 92812

5. ROE/UA COMP & PER DIEM
   - COL A: 6.604
   - COL B: 6.604
   - TOTAL: 71236

B. DIRECT CARE EXPENSE

1. Staffing
   - COL A: .5
   - COL B: 1
   - TOTAL: -

2. Total Staffing Required
   - COL A: 1230.5
   - COL B: 8325
   - TOTAL: 95555

3. Staffing Percent
   - COL A: 12.877%
   - COL B: 87.123
   - TOTAL: 100%

4. Alloc. of Direct Care
   - COL A: 39263.97
   - COL B: 26542.03
   - TOTAL: 304906

5. Dir. Care Exp. Per Diem
   - COL A: 15.945
   - COL B: 31.9090

C. ADDITIONAL SERVICES EXPENSE

1. Medicaid Patient Days
   - COL A: 2461
   - COL B: 8275
   - TOTAL: 10736

2. Add. Ser. (Sch.AM-6)
   - COL A: 36780
   - COL B: 69380
   - TOTAL: 106160

3. Add. Ser. Exp. Per Diem
   - COL A: 14.951
   - COL B: 8.3839

D. MEDICAID PER DIEM COST

1. Operating Component
   - COL A: 19.460
   - COL B: 19.460
   - TOTAL: 209897

2. Resident Care Component
   - COL A: 48.985
   - COL B: 58.378
   - TOTAL: 606133

3. Property Cost Component
   - COL A: 8.605
   - COL B: 8.605
   - TOTAL: 92812

4. ROE/USE ALLOW Comp.
   - COL A: 6.604
   - COL B: 6.604
   - TOTAL: 71236

5. TOTAL PER DIEM COST
   - COL A: 83.654
   - COL B: 93.047
   - TOTAL: 980078
APPENDIX B

CALCULATION OF THE
FLORIDA ICF/MR-DD COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>65.66%</td>
</tr>
<tr>
<td>Dietary</td>
<td>4.94%</td>
</tr>
<tr>
<td>All Other</td>
<td>29.40%</td>
</tr>
</tbody>
</table>

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>DRI INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>Wages and Salaries, combined</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others with other expenses</td>
<td>Fuel and Utilities, combined</td>
</tr>
</tbody>
</table>

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

DRI Wages and Salaries index = 1.043; Budget Share = .602
DRI Employee Benefits index = 1.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =

(1.043 x (.602/(.602 + .084))) + (1.073 x (.084/(.602 + .084))) = 1.047
3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/MR-DD Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

<table>
<thead>
<tr>
<th>Quarter Midpoint</th>
<th>Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984:1</td>
<td>1.029</td>
<td>1.032</td>
<td>March 31</td>
</tr>
<tr>
<td>1984:2</td>
<td>1.035</td>
<td>1.042</td>
<td>June 30</td>
</tr>
<tr>
<td>1984:3</td>
<td>1.048</td>
<td>1.054</td>
<td>September 30</td>
</tr>
<tr>
<td>1984:4</td>
<td>1.059</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 30 Index = (June 30 Index/March 31 Index)\(^{1/3}\) x (March 31 Index)
= (1.042/1.032)\(^{1/3}\) x 1.032
= 1.035

May 30 Index = (June 30 Index/March 31 Index)\(^{2/3}\) x (March 31 Index)
= (1.042/1.032)\(^{2/3}\) x 1.032
= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend must start with the index as of the last day of the month prior to the 12-month period.

Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.
average of inflation indices from
1984 Target factor = June 1983 through June 1984
average of inflation indices from
June 1982 through June 1983

\[
\begin{align*}
(0.994 + 0.999 + 1.004 + 1.009 + 1.014 + \\
1.018 + 1.023 + 1.026 + 1.029 + 1.032 + \\
= 1.035 + 1.039 + 1.042)/13
\end{align*}
\]

\[
\begin{align*}
(0.950 + 0.954 + 0.958 + 0.962 + 0.966 + 0.971 + \\
0.975 + 0.979 + 0.982 + 0.986 + 0.989 \\
0.992 + 0.994)/13
\end{align*}
\]

= 1.020

= 0.974

= 1.047

In the example above, the indices for June 30, 1982, .994, and June 30, 1983, .950 are taken to
represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the
fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for
a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.
I. Cost Finding and Cost Reporting

A. Each intermediate care facility for individuals with intellectual disabilities (ICF/IID) that is not publicly owned and not publicly operated participating in the Florida Medicaid program and being reimbursed under the provisions of this reimbursement plan shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked, or accepted by a common carrier, no later than five calendar months after the close of its cost reporting year. No exceptions will be granted to the filing time limits. Two complete, legible, copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. The cost reporting forms and instructions shall be the same as used for facilities reimbursed in accordance with Rule 59G-6.040, Florida Administrative Code (F.A.C.).

B. The most current cost report received by AHCA on or before February 1st each year shall be used to establish rates effective July 1 for all facilities that were being reimbursed in accordance with Rule 59G-6.040, F.A.C.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report shall be prepared using the accrual basis of accounting in accordance with generally accepted accounting principles and the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual Centers for Medicare and Medicaid Services (CMS) PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated, and State of Florida administrative rules. The CMS PUB.15-1 Manual may be obtained from the regional CMS office in Atlanta.
The person preparing the cost report shall sign the cost report as the preparer and include contact information. Cost reports not signed will not be accepted.

D. If a provider files a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been filed within five months, then the provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively.

E. A provider who voluntarily (or involuntarily) ceases to participate in the Florida Medicaid program or experiences a change of ownership (CHOW) shall file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with 42 Code of Federal Regulations (CFR), sections 413.24 (a), (b), (c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and shall be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records shall be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of three years following the date the cost report was filed with AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 shall be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to filed cost reports shall be in accordance with Chapter 119, Florida Statutes (F.S.).
I. New providers entering the program shall submit a cost report for a period of not less than 12 months and not greater than 18 months for purposes of setting prospective rates. Initial cost report must be filed not than 5 calendar months after the cost of the provider’s fiscal year end and are due not later than 23 months after the provider’s CHOW effective date. A partial-year cost report may be filed initially, but may only be used to adjust the interim budgeted rate in effect.

J. The provisions of this reimbursement plan shall apply to all ICF/IID facilities not publicly owned and not publicly operated. These facilities shall include ICF/IID facilities that are publicly owned and the State of Florida is the Medicaid provider of record, but are operated or managed by a not-for-profit or for profit organization.

K. Unless specifically noted, the terms facility and provider shall have the same meaning for all sections of this reimbursement plan.

L. Cost reports shall include the following statement immediately preceding the dated signature of the provider’s administrator or chief financial officer: “I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”

M. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

N. Providers are subject to sanctions pursuant to sections 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

All cost reports filed by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General
1. Primary responsibility for the audit of providers shall be assumed by AHCA. The efforts of AHCA audit staff may be augmented by contracts with certified public accountant (CPA) firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits, desk audits of cost reports, and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the American Institute of Certified Public Accountants.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor shall express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for three years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, F.S.

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Florida Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for each.

III. Allowable Costs

A. The cost report shall include all items of expense which a provider shall incur in meeting:

1. The definition of intermediate care facility set forth in 42 CFR 440.150.

2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act (SSA) in 42 CFR 442, Subpart C.
3. The requirements established by AHCA under the authority of 42 CFR 431.610.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative, or other professional treatments which shall be composed of medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy, or other intellectual disability specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense that providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses excluded from the cost report and reimbursable outside the per diem rate include:

- Practitioner services for acute events, including one visit per month for chronic care management
- Dialysis services rendered in the outpatient hospital or freestanding dialysis center setting
- Podiatry services
- Flu and pneumonia vaccines

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients’ responsibilities.

Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay $10.00. If the Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt.

Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters...
were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17, Medicare (Title XVIII) Principles of Reimbursement, and Chapter l0, CMS PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Other allowable costs shall be limited by the following provisions:

1. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:
   a. It is the intent of the Medicaid program to limit lease cost reimbursement (rent) to the allowable ownership costs associated with the leased land, building, and equipment. For the purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:
      (1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;
      (2) Sales tax on lease payments, if applicable; and
      (3) Return on equity (ROE) that would be paid to the owner if he were the provider, as per section H. below.
   b. Implementation of this provision shall be in accordance with the following:
      (1) Reimbursable lease costs of existing providers will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is,
increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record or the rent, whichever is lower.

(3) For new providers entering the Medicaid program, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs shall be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Florida Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's
costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the ICF/IID properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in section III.G.(3).

(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per four above.

3. Basis for depreciation and calculation:
   a. Cost.

   Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of subsection b. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 shall be followed.

   b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase 100 percent of the stock of the facility, and within one year, merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with section 1902(a)(13)(c) of the SSA, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for
determining payment rates for intermediate care facilities for individuals with
intellectual disabilities for facilities not publicly owned and publicly operated
shall be increased (as measured from the date of acquisition by the seller to the
date of the change of ownership), solely as a result of a change of ownership, by
the lesser of:

(1) One-half of the percentage increase (as measured over the same period
of time, or, if necessary, as extrapolated retrospectively by the
Secretary of HHS.) in the current Dodge Construction Systems Cost for
Nursing Homes, applied in the aggregate with respect to those facilities
which have undergone a change of ownership during the fiscal year; or

(2) One-half of the percentage increase (as measured over the same period
of time) in the current consumer price index for all urban consumers
(United States city average).

In any change in ownership, the total valuation of capital assets allowed for
determining payment rates shall not exceed the lesser of:

(1) The acquisition cost of the facility to the new owner; or

(2) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital
indebtedness, and, if applicable, ROE.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new
owner purchases the facility in 1990 for $700,000. The increase in the Dodge
Construction Index and the Consumer Price Index from the date of acquisition by the
seller to the date of change in ownership is 25% and 20% respectively. The new owner's
allowable depreciable basis is $550,000.
Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner's allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation.

The amount of the recapture shall be determined as follows:

(1) The gross recapture amount shall be the lesser of the actual gain on the sale or the Florida Medicaid portion of accumulated depreciation. The gross recapture amount shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program. Additional beds and other related depreciable assets put into service shall be subject to the same thirteen and one-half year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the
proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sales Price: $6,000,000
Older Portion of Facility:
Number of beds = 60
Newer portion of facility:
Number of beds = 120
Allocation to older portion: \( \frac{60}{180} \times 6,000,000 = 2,000,000 \)
Allocation to new portion: \( \frac{120}{180} \times 6,000,000 = 4,000,000 \)
Sale Price = $6,000,000

(2) The adjusted gross recapture amounts as determined in one above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in two above shall be paid by the former owners, to AHCA. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of
extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Florida Medicaid program.

(1) In cases where an owner-operator withdraws from the Florida Medicaid program as the provider, but does not sell the facility, the depreciation paid by Florida Medicaid to the owner during the same time he was the Florida Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated licensed operator after having operated the facility as the licensed Florida Medicaid provider. In addition, if an owner-operator elects to withdraw from the Florida Medicaid program and lease the facility to an operator who continues to participate in the Florida Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, section III.G.3.c, at the time the facility is sold. All owner-providers that withdraw from the Florida Medicaid program shall be required to sign a contract with the Agency for Persons with Disabilities (APD) creating an equitable lien on the owner's capital assets. This lien shall be filed by APD with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to AHCA upon sale of the facility. In the event that a provider fails to
sign and return the contract to APD, the Proof of Financial Ability, which is required for the prospective operator of the facility to be licensed, shall not be approved.

(2) For lessees entering the Florida Medicaid program and for existing Florida Medicaid providers who are granted an upward adjustment to their allowable lease costs, the portion of the Florida Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Florida Medicaid during the months that he was the Florida Medicaid provider or a lessor to a Florida Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation.

If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on ROE. ROE is also limited by the new owner's allowed acquisition cost. The new owner can receive an ROE upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive an ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per CMS PUB.15-1 provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including
building equipment, major movable equipment, and minor equipment as described in CMS PUB.15-1, shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been financed through a "conventional financing" debt instrument over a 25-year period, with a ten percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus two percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a ten percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in ROE or use allowance that would have occurred had a full ten percent down payment actually been made. If the total ROE payment would increase from zero to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments, with amortization of the principal beginning in the first year, that is, a 25-year payoff schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of the date the provider received a loan commitment from the lending institution, or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an
increase in their interest rate, but not to exceed that cost which would be
incurred at an interest rate of 15 percent per annum.
c. Additional costs due to refinancing shall not be allowed if refinancing was not
necessary in order to meet the final payments of the former debt instrument, that
is, in cases where balloon payments are due, or to finance the addition of new
beds.
d. AHCA shall make exceptions to the financing limitations set forth in (a) and (b)
above when, in consultation with the Agency for Persons with Disabilities
(APD), it is in the best interest of the State. Exceptions to the financing
limitations shall be considered when it has been demonstrated through the
Certificate of Need (CON) or Request for Proposal (RFP) process that financing
within the limitations of this plan is not available. Should that decision be made, the APD shall issue a new RFP allowing other
financing options. APD shall reject any or all proposals which are made in
response to a new RFP if APD determines that the rejection is in the best interest
of the State.

7. Additional costs incurred after enrollment in the program that are due to capital additions
or expansion shall have prior approval by the APD Office of Developmental Services if
such costs exceed one percent of the provider's current total reimbursement rate, with the
exception of the addition of new beds which are approved through the state's CON
process. Costs for specific expansions or additions that exceed the one percent limit shall
not be reimbursable if not previously approved. Further, financing costs for approved
expansions or additions shall be limited by the prudent buyer limits established in section
III.G(4).

8. Depreciable basis as a result of capital improvements. If capital improvements are made
to a facility, the actual cost of the improvements shall be added to the owner's basis,
allowing the owner reimbursement of interest, ROE, or both as specified in section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider shall maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Return on Equity

A reasonable ROE invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This ROE shall use the principles stated in Chapter 12, CMS PUB.15-1, except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Florida Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis.

I. Use Allowance

A use allowance on equity capital invested and used in providing resident care shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed only for non-profit providers, except for those facilities which are government-owned. This use allowance shall use the principles established in section H. above.

IV. Standards

A. In accordance with Chapter l20, F.S., Administrative Procedures Act (APA), this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.
B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in section IV.L. of this plan. Further, if certain costs are determined by the Florida Medicaid program or the Florida Medicaid Division of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established annually on July 1. The most current acceptable cost report received by AHCA by February 1 shall be used in the rate setting process to set rates effective on July 1.

D. Reimbursement rates shall be calculated separately for the following two levels of reimbursement:

1. Intermediate Care Facility Level of Reimbursement One - A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation.

2. Intermediate Care Facility Level of Reimbursement Two - A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.

Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers shall allocate costs by the two levels of care in their cost reports. AHCA shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If AHCA determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four types of care.
E. For the two classes described in section D. above, four components of the total reimbursement rate shall be calculated separately. These four components are operating costs, resident care costs, property costs, and ROE costs or use allowance, if applicable. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.
2. A provider files an amended cost report used to determine the rates in effect. An amended cost report may be filed in the event that it would effect a change of one percent or more in the total reimbursement rate. The amended cost report shall be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 60 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine annual rate setting process described in section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections IV.H. and IV. I.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of one percent or more in the provider's total per diem reimbursement rate.
2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of ten percent or more in the provider's current total per diem rate. The provider shall submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by AHCA and shall be the basis for establishing reasonable cost parameters. Interim rate requests resulting from (1), (2), and (3) above shall be filed within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, Florida Medicaid, Bureau of Medicaid Program Finance, shall determine whether additional information is needed from the provider and request such information...
within 30 days. Upon receipt of the complete, legible additional information requested, the Bureau of Medicaid Program Finance shall approve or disapprove the interim rate within 60 days. If Florida Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per section I.

5. The right to request interim rates shall not be granted for fiscal periods that have ended.

H.1. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

1. Property Costs:

   Shall be approved by Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. Operating Costs:

   Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. Resident Care Costs:

   Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.
H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:

1. Property Costs Ceiling:
   Shall be approved by the Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. Operating Costs Ceiling:
   Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. Resident Care Costs Ceiling:
   Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

4. Total costs per diem ceiling (including ROE):
   Shall not exceed $239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed $267.02 for the Developmental Non-Ambulatory classes.
   These ceiling amounts shall be inflated forward based on one times the ICF/IID inflation index utilizing the same inflation methodology as used in calculating prospective rates.
   When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including ROE.

<table>
<thead>
<tr>
<th>Example</th>
<th>Interim Cost</th>
<th>Percent to Total</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>58.15</td>
<td>23.26</td>
<td>55.82</td>
</tr>
<tr>
<td>Resident Care</td>
<td>158.89</td>
<td>63.56</td>
<td>152.54</td>
</tr>
<tr>
<td>Property</td>
<td>25.70</td>
<td>10.28</td>
<td>24.67</td>
</tr>
</tbody>
</table>
I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12 month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Florida Medicaid.

I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in section V.B. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Florida Medicaid.

J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/IID Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in section V.A.(7). of this plan.
K. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any condition of participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set.

L. A provider's reimbursement for service provided under the Florida Medicaid program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

M. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida ICF/IID Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.

N. Aggregate test comparing Florida Medicaid to Medicare according to 42 CFR section 447.253(c)(2), Florida Medicaid estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.
O. **Base Costs:**

The initial base costs for each provider shall be the allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Florida Medicaid program the initial base costs shall be established in accordance with section IV.I. of this plan. Prospective rates calculated using unaudited costs shall be retroactively adjusted when audit results become available.

**P.** Effective July 1, 2011 through June 30, 2015, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

---

**V. **Methodology

**A. Rate-setting method for rate periods beginning on or after July 1, 2014.**

1. For rate periods beginning on July 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year.

2. Review and adjust each provider’s cost report referred to in section IV.N. to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and ROE or use allowance if applicable. See the glossary section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.

4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly
Florida ICF/IID Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.

6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet state or federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and one percent threshold under the interim rate provisions in section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider shall furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in step five above to reflect the allowable change in costs.

7. Compare the operating and resident care cost per diems resulting from step six with the respective per diems from step four for each reimbursement class.

a. If the operating per diem for either reimbursement class from step four is less than the respective operating per diem from step six, then establish the new operating base per diem as the per diem from step four plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the step four per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate period in effect one year prior to the rate period.
being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the operating per diem from step four is greater than the step six per diem, then establish the new operating base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

b. If the resident care per diem for either reimbursement class from step four is less than the respective resident care per diem from step six then establish the new resident care base per diem as the per diem from step four plus an incentive calculated as 50 percent of the difference between the step four per diem and the step six per diem, not to exceed three percent of the step four per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a condition of participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the resident care per diem from step four is greater than the step six per diem, then establish the new resident care base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

c. If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of
each class. This shall equalize the operating rate cost components and allow for
more meaningful trend comparison between cost reporting periods.

8. The new base per diems for property and ROE or use allowance shall be the per diems
established in step four above.

9. Using the appropriate current base per diem for resident care and operating costs from
step seven above, calculate the prospective operating and resident care per diems for the
new rate period by multiplying each of the base per diems by the fraction:
Simple average of the Florida ICF/IID monthly cost inflation indices for the prospective
rate period divided by the simple average of the Florida ICF/IID monthly cost inflation
indices for the cost report period used to calculate current base per diems.

10. Establish the total prospective per diem for each reimbursement class as the sum of the
appropriate operating and resident care per diems resulting from step nine plus the
current approved per diems for property and ROE or use allowance, if applicable, from
step eight.

B. Florida Medicaid Trend Adjustment (MTA) – For Rate Periods on or After
July 1, 2014

1. Effective July 1, 2014, reimbursement rates for intermediate care facilities will be set
July 1 of each year. Between July 1, 2014 and April 30, 2016, providers may elect to
change their fiscal year end and file a new cost report for a period of not less than 6
months and not greater than 18 months due to the transition to an annual rate setting. Cost
report fiscal year end changes for this purpose are allowed even if a recent change has
occurred and cost reports have not been filed with the same fiscal year end for two years.

2. Effective July 1, 2015, $39,127,138 is provided to buy-back intermediate care facilities
rate reductions, effective on or after October 1, 2008.
3. The recurring methodology to establish rates taking into consideration the cuts imposed on or after October 1, 2008, shall be to compare the legislative unit cost with the rate setting unit cost as follows:

1) The legislative unit cost shall be determined by dividing the total appropriation for intermediate care facilities by the total bed days for the past fiscal year;

2) The total actual cost as generated based on the July 1 rate settings shall be divided by the total bed days for the past fiscal year to determine the rate setting unit cost;

3) The rate setting unit cost shall be reduced to a “reduced rate setting unit cost” by the same percentage used to calculate the legislative unit cost to account for client participation contributions;

4) No negative adjustment to the rates paid to providers shall occur so long as the reduced rate setting unit cost is equal to or less than the legislative unit cost; and

5) In the event the reduced rate setting unit cost is greater than the legislative unit cost, a prorated reduction shall be imposed on all rates after all quality assessment fee funds have been exhausted to cover the rate reductions.

C. Base year ceilings for new providers in facilities with six beds or less

1. Property costs per diems shall not be in excess of the ceiling limitations established in section III.

2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/IID providers that have prospective rates. This ceiling shall be recalculated for every rate period beginning July 1 of each year.

3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate period beginning July 1 of each year.

4. Total costs per diem ceilings (including ROE):
Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.(2)(D.). multiplied times 1.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including ROE, in the base year.

Example:

<table>
<thead>
<tr>
<th>Component</th>
<th>Interim Cost</th>
<th>Percent to Total</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>58.15</td>
<td>23.26</td>
<td>55.82</td>
</tr>
<tr>
<td>Resident Care</td>
<td>158.89</td>
<td>63.56</td>
<td>152.54</td>
</tr>
<tr>
<td>Property</td>
<td>25.70</td>
<td>10.28</td>
<td>24.67</td>
</tr>
<tr>
<td>ROE</td>
<td>7.26</td>
<td>2.9</td>
<td>6.97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100%</strong></td>
<td><strong>240</strong></td>
</tr>
</tbody>
</table>

**VI. Payment Assurance**

AHCA shall pay each provider for services provided in accordance with the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX Reimbursement Plan for IID Services in Facilities Not Publicly Owned and Not Publicly Operated.

**VII. Provider Participation**

This plan is designed to assure adequate participation of ICF/IID providers in the Florida Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.
VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the state plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to an ICF/IID facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid resident and shall be deemed to be out of compliance with 42 CFR section 447.15.

IX. Intermediate Care Facility Quality Assessment Fee (ICFQAF)

A. In accordance with section 409.9083, F.S., there is imposed upon each ICF/IID, a quality assessment. The aggregated amount of assessments for all ICF/IID’s in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. AHCA shall calculate the quality assessment rate annually on a per resident-day basis as reported by the facilities. The per-resident per day assessment rate shall be uniform. Each facility shall report monthly to AHCA its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. AHCA shall collect, and each facility shall pay, the quality assessment each month. AHCA shall collect the assessment from facility providers no later than the 15th of the next succeeding calendar month. AHCA shall notify providers of the quality assessment rate and provide a standardized form to complete and submit with payments. The collection of the quality assessment shall commence no sooner than 15 days after the agency’s initial payment to the facilities that implement the increased Florida Medicaid rates containing the elements prescribed in section B below and monthly thereafter. Intermediate care

Amendment: 2016-028
Supersedes: 2015-011
Approval Date: 3/24/2017
Effective Date: July 1, 2016
facilities for individuals with intellectual disabilities may increase their rates to incorporate the assessment but may not create a separate line-item charge for the purpose of passing through the assessment to residents.

B. The purpose of the facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Florida Medicaid program to make Florida Medicaid payments for ICF/IID services up to the amount of the Florida Medicaid rates for such facilities as calculated in accordance with the approved state Florida Medicaid plan in effect on April 1, 2008. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority to:

   (a) Reimburse the Florida Medicaid share of the quality assessment as a pass through, Florida Medicaid-allowable cost.
   
   (b) Increase each privately operated ICF/IID Florida Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.
   
   (c) Increase each ICF/IID Florida Medicaid rate, as needed, by an amount that restores any rate reductions for the 2008-2009 fiscal year and the 2009-2010 fiscal year.
   
   (d) Increase payments to such facilities to fund covered services to Florida Medicaid beneficiaries.

C. Upon termination of the quality assessment, all collected assessment revenues, less any amounts expended by AHCA, shall be returned on a pro rata basis to the facilities that paid such assessments.

X. Glossary

A. Acceptable cost report- A completed, accurate and legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. APD - Agency for Persons with Disabilities.

C. AHCA - Agency for Health Care Administration.

D. Client participation contributions - See (M) Patient Responsibility.

E. CMS PUB.15-1- also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Florida Medicaid Services.

F. Filing due date (Cost Report) - No later than five calendar months after the close of the ICF’s cost-
reporting year.

G. ICF/IID operating costs - Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

H. ICF/IID resident care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

I. ICF/IID property costs - Those costs related to the ownership or leasing of an ICF/IID. Such costs may include property taxes, insurance, interest and depreciation, or rent.

J. ICF/IID return on equity or use allowance costs - See sections III.H. and III.I. of this plan.

K. Initial cost report – The ICF/IID first filed cost report containing actual costs following the budget interim period associated with their fiscal year end.

L. Late cost report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program. Analysis after the filing due date and after the rate setting due date.

M. Legislative unit cost - The weighted average per diem of the state anticipated expenditure.

N. Medicaid interim reimbursement rate – A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

O. Patient Responsibility- Florida Medicaid deducts the portion of a recipient’s monthly income, as determined by the Department of Children and Families (DCF), that the recipient is required to pay.

P. Quality assessment fee - Pursuant to section 409.9083, F.S., a per-resident-day basis assessment is imposed upon each intermediate care facility.

Q. Medicaid interim reimbursement rate - A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

R. Rate setting due date - All cost reports received by AHCA by February 1 shall be used to establish the reimbursement rates. If the due date falls on the weekend, the rate setting due date is the first business day following February 1.

S. Rate setting unit cost - The weighted average per diem based on filed cost reports.
T. Reduced rate setting unit cost - The rate setting unit cost after it is reduced by the same percentage that was used to calculate the legislative unit cost in order to account for the client participation contributions.

U. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the SSA (42 U.S.C. 1395-1395pp).

V. Title XIX - Grants to States for Medical Assistance Programs (Medicaid) as provided for in the SSA (42 U.S.C. 1396-1396i).
### APPENDIX A
#### CALCULATION OF PROVIDER COST ALLOCATION

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>FY: 09/30/84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Audit Status Unaudited</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>COL A</th>
<th>COL B</th>
<th>COL C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resid./Non-amb./Inst.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Alloc of Exp (Excl B&C)

1. **Resident Days**
   - 02461 | 8325 | 10786

2. **OPER. EXPENSE COMP**
   - **Administration**: - | - | 120482
   - **Plant Operation**: - | - | 45060
   - **Laundry**: - | - | 15265
   - **Housekeeping**: - | - | 29090
   - **Oper. Exp. Comp and Per Diem**: 19.460 | 19.460 | 209897

3. **Resident Care Expense**
   - **Dietary**: - | - | 74861
   - **Other**: - | - | 34188
   - **Nursing**: - | - | 86018
   - **Res. Care Exp. and Per Diem**: 18.0852 | 18.0852 | 19.5067

4. **PROP. EXP. COMP. AND PER DIEM**: 8.605 | 8.605 | 92812

5. **ROE/UA COMP & PER DIEM**: 6.604 | 6.604 | 71236

#### B. DIRECT CARE EXPENSE

1. **Staffing** .5 | 1. -
2. **Total Staffing Required**: 1230.5 | 8325 | 95555
3. **Staffing Percent**: 12.877% | 87.123 | 100%
4. **Alloc. of Direct Care**: 39263.97 | 26542.03 | 304906
5. **Dir. Care Exp. Per Diem**: 15.945 | 31.9090 |

#### C. ADDITIONAL SERVICES EXPENSE

1. **Medicaid Patient Days**: 2461 | 8275 | 10736
2. **Add. Ser. (Sch.AM-6)**: 36780 | 69380 | 106160

#### D. MEDICAID PER DIEM COST
<table>
<thead>
<tr>
<th></th>
<th>Operating Component</th>
<th>19.460</th>
<th>19.460</th>
<th>209897</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Resident Care Component</td>
<td>48.985</td>
<td>58.378</td>
<td>606133</td>
</tr>
<tr>
<td>3.</td>
<td>Property Cost Component</td>
<td>8.605</td>
<td>8.605</td>
<td>92812</td>
</tr>
<tr>
<td></td>
<td>Subtotal (Schedule BM)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>ROE/USE ALLOW Comp.</td>
<td>6.604</td>
<td>6.604</td>
<td>71236</td>
</tr>
<tr>
<td>5.</td>
<td>TOTAL PER DIEM COST</td>
<td>83.654</td>
<td>93.047</td>
<td>980078</td>
</tr>
</tbody>
</table>
APPENDIX A-1

CALCULATION OF PROVIDER COST ALLOCATION

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>FY: 09/30/84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Audit Status Unaudited</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>COL A</th>
<th>COL B</th>
<th>COL C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resid./</td>
<td>Non-amb./</td>
<td>Inst.</td>
</tr>
</tbody>
</table>

A. Alloc of Exp (Excl B&C)

1. Resident Days 2461 8325 10786

2. OPER. EXPENSE COMP
   a. Administration - - 120482
   b. Plant Operation - - 45060
   c. Laundry - - 15265
   d. Housekeeping - - 29090
   e. Oper. Exp. Comp and Per Diem 19.460 19.460 209897

3. Resident Care Expense
   a. Dietary - - 74861
   b. Other - - 34188
   c. Nursing - - 86018
   d. Res. Care Exp. and Per Diem 18.0852 18.0852 195067

4. PROP. EXP. COMP. AND PER DIEM 8.605 8.605 92812

5. ROE/UA COMP & PER DIEM 6.604 6.604 71236

B. DIRECT CARE EXPENSE

1. Staffing .75 1. -

2. Total Staffing Required 1845.75 8325 10,171

3. Staffing Percent 18.148% 81.852% 100%

4. Alloc. of Direct Care 55,334.34 249,571.66 304906

5. Dir. Care Exp. Per Diem 22.484 29.979

C. ADDITIONAL SERVICES EXPENSE

1. Medicaid Patient Days 2461 8275 10736

2. Add. Ser. (Sch.AM-6) 36780 69380 106160


D. MEDICAID PER DIEM COST

1. Operating Component 19.460 19.460 209897
<table>
<thead>
<tr>
<th></th>
<th>Resident Care Component</th>
<th>55.520</th>
<th>56.448</th>
<th>606133</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Property Cost Component</td>
<td>8.605</td>
<td>8.605</td>
<td>92812</td>
</tr>
<tr>
<td></td>
<td>Subtotal (Schedule BM)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>ROE/USE ALLOW Comp.</td>
<td>6.604</td>
<td>6.604</td>
<td>71236</td>
</tr>
<tr>
<td>5.</td>
<td>TOTAL PER DIEM COST</td>
<td>90.189</td>
<td>91.117</td>
<td>980078</td>
</tr>
</tbody>
</table>
APPENDIX B

CALCULATION OF THE
FLORIDA ICF/IID COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>65.66%</td>
</tr>
<tr>
<td>Dietary</td>
<td>4.94%</td>
</tr>
<tr>
<td>All Other</td>
<td>29.40%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>DRI INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits with Employee Benefits</td>
<td>Wages and Salaries, combined</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others with other expenses</td>
<td>Fuel and Utilities, combined</td>
</tr>
</tbody>
</table>

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

DRI Wages and Salaries index = 1.043; Budget Share = .602

DRI Employee Benefits index = 1.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =

\[
(1.043 \times (.602/(.602 + .084))) + (1.073 \times .084/(.602 + .084)) = 1.047
\]
Appendix B
Page 2

3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/IIDIID Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

<table>
<thead>
<tr>
<th>Quarter Midpoint</th>
<th>Quarter Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984:1</td>
<td>1.029</td>
<td>1.032</td>
<td>March 31</td>
</tr>
<tr>
<td>1984:2</td>
<td>1.035</td>
<td>1.042</td>
<td>June 30</td>
</tr>
<tr>
<td>1984:3</td>
<td>1.048</td>
<td>1.054</td>
<td>September 30</td>
</tr>
<tr>
<td>1984:4</td>
<td>1.059</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 30 Index = (June 30 Index/March 31 Index)\(^{1/3}\) x (March 31 Index) = (1.042/1.032)\(^{1/3}\) x 1.032 = 1.035

May 30 Index = (June 30 Index/March 31 Index)\(^{2/3}\) x (March 31 Index) = (1.042/1.032)\(^{2/3}\) x 1.032 = 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend shall start with the index as of the last day of the month prior to the 12-month period.

Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.
average of inflation indices from
1984 Target factor = June 1983 through June 1984
average of inflation indices from
June 1982 through June 1983

\[
\frac{.994 + .999 + 1.004 + 1.009 + 1.014 + \\
1.018 + 1.023 + 1.026 + 1.029 + 1.032 + \\
= 1.035 + 1.039 + 1.042}{13}
\]

\[
\frac{.950 + .954 + .958 + .962 + .966 + .971 + \\
.975 + .979 + .982 + .986 + .989 + \\
.992 + .994}{13}
\]

= 1.020

\[
.974
\]

= 1.047

In the example above, the indices for June 30, 1982, .994, and June 30, 1983, .950 are taken to represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.
## APPENDIX C

### Florida Medicaid Trend Adjustment Percentages

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Percentages</th>
<th>Reduction Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2008</td>
<td>0.8200%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>2. October 1, 2009</td>
<td>0.7577%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td></td>
<td>8.7004%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>April 1, 2010</td>
<td>0.8145%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td></td>
<td>9.3580%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>October 1, 2010</td>
<td>0.7878%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td></td>
<td>9.0489%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>April 1, 2011</td>
<td>0.8539%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td></td>
<td>9.8141%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>October 1, 2011</td>
<td>0.8555%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td></td>
<td>9.8325%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td></td>
<td>3.9527%</td>
<td>$6,297,463</td>
</tr>
<tr>
<td>April 1, 2012</td>
<td>0.4245%</td>
<td>$762,299</td>
</tr>
<tr>
<td></td>
<td>9.7180%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td></td>
<td>3.0000%</td>
<td>$3,590,754</td>
</tr>
<tr>
<td>October 1, 2012</td>
<td>1.667%</td>
<td>$4,605,776</td>
</tr>
<tr>
<td>Rate Freeze Cut</td>
<td>0.9335%</td>
<td>$2,368,814</td>
</tr>
<tr>
<td>April 1, 2013</td>
<td>1.117617%</td>
<td>$3,026,468</td>
</tr>
<tr>
<td>Rate Freeze Cut</td>
<td>1.2163%</td>
<td>$3,086,633</td>
</tr>
<tr>
<td>October 1, 2013</td>
<td>0.00715156%</td>
<td>$1,984,589</td>
</tr>
<tr>
<td>Rate Freeze Cut</td>
<td>1.2776396%</td>
<td>$3,247,165</td>
</tr>
<tr>
<td>Date</td>
<td>Rate Adjustment</td>
<td>Rate Freezed Cut</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>April 1, 2014</td>
<td>0.00%</td>
<td>.002146435%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2014</td>
<td>0.00%</td>
<td>.016149365%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>2.7853567%</td>
<td></td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>July 1, 2017</td>
<td>2.72709484%</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Upper Payment Limit Methodology

ICF/IID Upper Payment Limit (UPL) Methodology

The UPL is an estimation of the amount that would be paid under Medicare payment principles (the Medicare UPL) which is basis for the following UPL methodology:

Determine Medicare Cost Per Day

1. Utilizing cost and utilization data from ICF/IID cost reports for fiscal year 2013-2014 (the Medicare UPL base year)
2. Compute 112% of the weighted mean cost per patient day (the 112% amount).
3. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
4. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
5. Calculations for future fiscal years – 1) By trending the Weighted Mean Cost Per Day forward by the CMS Nursing Home Price Index or 2) A new Medicare UPL base year will be designated and a new Weighted Mean Cost Per Day will be trended forward.

Determine Medicare UPL Payment

1. To determine the Medicare UPL for each state fiscal year beginning with the base year. For this UPL demonstration, State Fiscal Year 2013-2014 is the base. A 2012 Weighted Mean Cost Per Day is calculated and trended. This figure is multiplied by the 2012 Medicaid days.

Determine Medicaid Payment
1. To determine the Florida Medicaid payment for each state fiscal year beginning with state fiscal year 2012-14, take the total actual paid amount from the Florida Medicaid Management Information System (FMMIS) for each ICF/IID Florida Medicaid provider.

Determine UPL Difference in Payments

1. The difference is determined by subtracting the Medicare UPL payment from the Florida Medicaid payment for each year.