FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION XVIII EFFECTIVE DATE: April 1, 2000

I. Cost Finding and Cost Reporting

A. Each provider participating in the Florida Medicaid nursing home program shall submit a uniform cost report and related documents required by this plan using Agency for Health Care Administration (AHCA) form AHCA 5100-000, Rev. 7-1-90, as revised and prepared in accordance with the related instructions, 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 for filing cost reports. Three complete, legible copies of the cost report shall be submitted to AHCA.

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 or existing facility entering the program or an existing provider in a newly constructed replacement facility, the interim operating and patient care cost per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted operating and patient care cost per diems approved by AHCA based on Section III of this plan, or the average operating and patient care per diems (excluding incentives) in the district in which the facility is located plus 50% of the difference between the average district per diem (excluding incentives) and the facility class ceiling. Existing providers in a newly constructed replacement facility shall receive the greater of the above operating and patient care cost per diems or their current operating and patient care per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility class ceilings. The average district per diem is calculated by taking the sum of all operating and patient care per diems divided by the number

of facilities. For a new provider with no cost history resulting from a change of ownership or operator, where the previous provider participated in the Medicaid program, the interim operating and patient care per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted per diems approved by AHCA based on Section III of this Plan, or the previous providers' operating and patient care cost per diem (excluding incentives), plus 50% of the difference between the previous providers' per diem (excluding incentives) and the class ceiling. The above new provider ceilings, based on the district average per diem or the previous providers' per diem, shall apply to all new providers with a Medicaid certification effective on or after July 1, 1991. The new provider reimbursement limitation above, based on the district average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate semester in which the target reimbursement provision in Section V.B.16. of this plan does not apply. This new provider reimbursement limitation shall apply to new providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.16. of this plan does not apply. New provider ceilings applicable to the first rate semester a new provider enters the program shall be the basis for calculating subsequent rate semester new provider target ceilings for that same provider through the following calculation: Effective July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient care cost in Step V.B.16. from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR) with the quantity:

$$1 + 1.4 \times \left(\frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}} - 1 \right)$$

In the above calculation, the 1.4 shall be referred to as the inflation multiplier. New providers limited by this section for the patient care component for the January 1, 2000 rate semester only shall be entitled to a similar adjustment in the inflation multiplier as described in Section V. B.16.

For new providers who enter the program operating a facility that had been previously operated by a Medicaid provider, the property reimbursement rate shall be established per Section V.E.4. of this plan. The property cost per diem for newly constructed facilities or replacement facilities shall be the lesser of: the budgeted fair rental value rate approved by AHCA based on Section V.E. of this plan; or the applicable fair rental value based upon the cost per bed standard that was in effect 6 months prior to the date the facility was first put in service as a nursing home. Return on equity or use allowance per diems shall be the budgeted rate approved by AHCA per Section III of this plan. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but less than 18 months. Cost reporting periods ending on or after July 1, 1991, shall be for periods 6 months or more but less 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.

C. The cost report shall be prepared by a Certified Public Accountant in accordance with Chapter 409.908, Florida Statutes, on the form prescribed 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) 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 (HCFA-PUB.15-1) (1993) 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 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 as incorporated by reference in Rule 61H1-20.008, F.A.C., and AICPA statements on auditing standards. Cost reports, which are not signed by a Certified Public Accountant, or are not accompanied by a separate letter signed by a CPA, shall not be accepted.

D. All prior year cost reports must be submitted to and accepted by the Agency, before the current year cost report may be accepted for rate setting.. If a provider submits a cost report late, after 3 calendar months, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 3 calendar months, then the providers' 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. 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 semester had it been submitted within 3 calendar months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft or wind.

E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, HCFA-PUB.15-1 (1993) 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 CFR 413.24 (1998), sections (a),(b),(c), and (e). The cost report is to be based on financial and statistical records maintained by the facility. 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 HCFA PUB.15-1 (1993) 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 5 years following the date of submission of the cost report form to AHCA.

G. Records of related organizations as identified by 42 CFR 413.17 (1998) 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 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 (1998). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing home care in accordance with this Plan are

subject to an audit or desk review on a random basis and at any time the agency 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. 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 (1998) will be met.
2. All audits shall be based on generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., of the AICPA.
3. Upon completion of each audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 (1998) and generally accepted auditing standards as incorporated by reference in Rule 61H1- 20.008, F.A.C. 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 the reimbursement program for long-term care facilities. All reports shall beretained by AHCA for 3 years.
4. The provider's copy of the audit report shall include all audit adjustments and changes and the authority for each, and all audit findings and shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

1. Upon receipt of a cost report from the provider prepared in accordance with instructions furnished by the agency, the agency will determine whether an audit or desk review is to be performed. Providers selected for

audit or desk review will be notified in writing of the AHCA Audit Office or CPA firm assigned to perform the audit or desk review.

2. Upon completion of an audit or desk review and before publication of the audit of 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 ten (10) days before the exit conference. If the provider fails to schedule an exit conference within twenty 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 the agency's office in Tallahassee.

3. Following the exit conference, the provider has sixty (60) calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. For adjustments made due to lack of adequate documentation or lack of support, any documentation received after the sixty day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the sixty-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.

4. All audit or desk review reports shall be issued by certified mail, return receipt requested and shall be mailed to the address of the nursing home to the attention of the administrator. The provider shall have twenty-one (21) calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustment or audit or desk review finding contained in the report by requesting an administrative hearing in

accordance with Section 120.57, Florida Statutes and Chapter 28.106, Florida Administrative Code. 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 Medicaid reimbursement. Except as otherwise provided this Plan, Chapter 28-106, Florida Administrative Code shall be applicable to any administrative proceeding under this Plan.

5. Collection of overpayments or refunds of amounts collected in error will be in accordance with Section 414.41, Florida Statutes and Rule 59G-9.010.

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.
2. The standards prescribed by the Secretary of HHS for nursing facilities in regulations under the Social Security Act in 42 CFR 483 (1998), 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 (1998); and

B. All therapy required by 42 CFR 409.33 (1999) 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 therapies include physical therapy, audiology, speech pathology and occupational therapy.

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, HCFA-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.

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. The following are examples of expenses that allowable costs for routine services shall include:

(l) All general nursing services, for example: oxygen and related medications, hand feeding, incontinency care, tray service, and enemas;

(2) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans;

(3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-legend drugs ordinarily kept on hand, suppositories, and tongue depressors;

(4) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(5) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician because these supplements have been classified by the Food and Drug Administration as a food rather than a drug; and

(6) Laundry services other than for personal clothing, prior to October 1, 1993.

(7) Effective October 1, 1993, laundry services, including basic personal

laundry services , but excluding dry cleaning, mending, handwashing or other specialty services, shall be an allowable cost.

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 rate is $34.00; State pays $26.00 and patient is to pay $8.00. If Medicaid patient pays only $6.00, then $2.00 would be an allowable bad debt. All Medicaid Title XIX bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters, etc.

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 Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, HCFA-PUB.15-1 (1993). 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:

l. The Owner-Administrator and Owner-Assistant Administrator compensation shall be limited to reasonable levels determined in accordance with HCFA-PUB.15-1 (1993) 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 survey results shall be updated each year

by the wage and salary component of the plan's inflation index. A new salary survey shall be conducted every 3 years.

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; and

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

   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 (See Appendix B), used for property cost ceiling calculations in Section V., during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 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, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

c. (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 Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the allowable ownership costs of the leased property per Section III.G.3.-5.

(2) Annual increases in lease costs for providers in (l) above shall be limited to the increase in the Florida Construction Cost Inflation Index, used for property cost ceiling calculations in Section V, during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 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, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

d. (1) Facilities leased on or after October 1, 1985 shall be reimbursed for lease costs and other property costs based on the FRVS per Section V.E.1.a.-g. of this plan. Allowable ownership costs shall be documented to AHCA for purposes of computing the fair rental value.

Facilities not reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan shall not be reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan, solely due to the execution of a lease agreement between related organizations under Section III.F. of this plan.

(2) In no case shall Medicaid reimburse property costs of a provider who is subject to b., c., and d.(1) above and e. below if ownership costs are not properly documented per the provisions of this plan. Providers shall not be reimbursed for property costs if proper documentation, capable of being verified by an auditor, of the owner's costs is 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 nursing home properties available to auditors or official representatives of AHCA.

(3) Approval shall not be given for a 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) above.

e. A lease agreement may be assigned and transferred (assumed) for 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 Medicaid reimbursement purposes.

(3) The lease agreement includes provisions which 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, reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per Section V.E.1.a.-g. of this plan.

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 3b. and 6. below. All provisions of the Medicare (Title XVIII) Principles of Reimbursement and HCFA-PUB.15-1 (1993) 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 l00 percent of the stock of the facility and within 1 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 occurs, and if a bona fide sale is established, the basis for depreciation shall be the lower of:

1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 (1998) and determined by an appraiser who meets the requirements of Section 59A-4.103 (6) (I) 9. b. Florida Administrative Code;

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 begin operation after July 18, 1984; or

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

Example 1: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $1,000,000.00. The new owner's basis for depreciation is the lesser of the two, or $500,000.00.

Example 2: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $300,000.00. The new owner's basis for depreciation is the lesser of the two, or $300,000.00.

4. Limitation on interest expense for property-related debt and on return on equity or use allowance. At a change of ownership on or after July 18, 1984, the interest cost and return on equity or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. above. The new owner shall be allowed the lesser of actual costs or interest cost and return on equity 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 return on equity or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b. above.

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. above. 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 $600,000.00. The new owner pays $1,000,000.00 for the facility, makes a down payment of $200,000.00 and finances $800,000.00 at 15 percent for 25 years. The basis for depreciation to the new owner is $600,000.00, and the disallowed portion of the depreciable basis is $400,000.00. Therefore, the allowable equity attributable to investment in the capital assets is $200,000.00, and interest cost allowed shall be computed on $400,000.00 ($600,000.00 minus $200,000.00) at 15 percent over 25 years.

Example 2: If the new owner above had made a down payment of $700,000.00 and financed $300,000.00, the allowable equity would be $600,000.00, 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 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 Medicaid certification effective on or after July 1, 1991.

	Example 1	Example 2
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

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 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 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 applicable to payments made to facilities 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 1.00 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 1/3 year depreciation recapture phaseout 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 1.00 percent for each month in excess of 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 sales price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000

Older Portion of facility:

Number of beds = 60

Newer portion of facility:

Number of beds = 120

Allocation to older portion: (60/180) x 6,000,000 = $2,000,000

Allocation to new portion: (120/180) x 6,000,000 = $4,000,000

Sale Price $6,000,000

(b) The adjusted gross recapture amounts as determined in (a) above 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) 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 part, the amount not paid shall be deducted from the 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 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 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 a licensed Medicaid provider. After April 1, 1983, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the Agency creating an equitable lien on the owner's nursing home assets. This lien shall be filed by the Agency with the clerk of the Circuit Court in the Judicial Circuit within which the nursing home 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 the Agency upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid program, the reduction in the gross depreciation recapture amount calculated in Section III. H.1.(a) above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients. EXAMPLE: An owner-operator participates in Medicaid for 60 months. He then withdraws from the Medicaid program and leases the facility to a new operator, who enters the Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Medicaid program and operates the facility for another 5 years, 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 Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be (60+24 - 48) months times 1.00 percent. If a provider

fails to sign and return the contract to the Agency, 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 facility.

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 facility has been reimbursed under FRVS;

(b) For months 61 and subsequent, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the facility had Medicaid utilization greater than 55 percent for a majority of the months that the facility was reimbursed under FRVS; and

3. Documented costs of replacement equipment purchased subsequent to FRVS payments and for which additional payments were not made per Section V.E.1.j. shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity.

A reasonable return on equity (ROE) for capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the principles stated in Chapter l2, HCFA-PUB.15-1 (1993) 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 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. 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 return on equity payment shall be calculated on 20 percent of the FRVS asset valuation per Section V.E. 1.e. of this plan 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 Chapter 12, HCFA-PUB.15-1 (1993) established in Section J. above, 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 governmentally owned or operated facilities, all provisions of J. above, 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, relating to Medicaid audits, Medicaid cost reimbursement cases, including administrative rules, administrative rules affecting Medicaid policy, 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.

IV. Standards

A. In accordance with Section l20, Florida Statutes, Administrative Procedures 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 home within the State shall be classified into one of six reimbursement classes as defined in V. A.3 of this plan. Separate reimbursement ceilings shall be established for each class. Separate operating and patient care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a

statewide reimbursement ceiling for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January l and July l. The most current cost reports postmarked or accepted by a common carrier by September 30 and March 3l and received by October l5 and April l5, respectively, shall be used to establish the operating and patient care class ceilings. Beginning with the January 1, 1988, rate period additional ceilings based on the Target Rate System shall also be imposed. Beginning with the July 1, 1991 rate period, additional ceilings for new providers shall also be imposed. The first cost report submissions for all newly-constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end of these newly-constructed facilities shall be after October l, l977. In addition, all facilities with year ends prior to that of the one hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceilings. Ceilings shall be set at a level which the State determines to be adequate to reimburse the allowable and reasonable costs of an economically and efficiently operated facility. The property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan pending transition to payments based on the FRVS shall be the ceiling in effect at July 1, 1985. The operating and patient care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating and patient 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. A provider shall be exempt from the operating and patient care class ceilings and target rate ceilings if all of the following criteria are satisfied:

a) All of the resident population are dually diagnosed with medical and

psychiatric conditions.

b) No less than 90 percent of the resident population suffer from at least one of the following: severe behavioral, emotional, or cognitive difficulties resulting from their psychiatric impairment.

c) The facility provides clinically appropriate care to address these behavioral, cognitive, and emotional deficits.

d) A medically approved individual treatment plan is developed and implemented for each patient. The plan comprehensively addresses the client's medical, psychiatric, and psychosocial needs.

e) The facility complies with the licensure provisions for specialty psychiatric hospitals in accordance with Rule 59A-3 FAC.

f) The facility complies with HRSR 95-3 with regard to psychotropic drugs or establish written facility standards which meet or exceed this regulation.

g) The facility complies with HRSM 180-1 with regard to quality assurance procedures or establishes written facility standards which meet or exceed this regulation.

Beginning on or after January l, l984, provider whose reimbursement rates are limited to the class ceiling for operating and patient care costs shall have their reimbursement exceeded under the circumstances described below. The provider must demonstrate to the Agency that unique medical care requirements exist which require extraordinary outlays of funds causing the provider to exceed the class ceilings. Circumstances which shall require such an outlay of funds causing a provider to exceed the class ceilings as referenced above shall be limited to:

a) Acquired Immune Deficiency Syndrome (AIDS) diagnosed patients requiring isolation care;

b) Medically fragile patients under age 21 who require skilled nursing care.

The period of reimbursement in excess of the class ceilings shall not exceed 6 months. A flat rate shall be paid for the specific patients identified, in addition to the average per diem paid to the facility. The flat rate amount for AIDS patients shall include the costs of incremental staffing and isolation supplies, and shall be trended forward each rate semester using the DRI indices used to compute the operating and patient care ceilings. The flat rate payment for Medically fragile patients under age 21 who require skilled nursing care shall be the same as the flat rate payment for "grandfathered in" ventilator patients, and shall be trended forward using the DRI indices in the same manner as the payment for AIDS patients. Patients requiring the use of a ventilator and related equipment whose costs were approved under the 10/1/85 reimbursement plan shall be "grandfathered in"--that is, a flat rate shall be paid for incremental staffing costs only. Costs of the ventilator and related equipment, that is, rent, depreciation, interest, insurance and property taxes, shall be paid in addition to the flat rate. No new ventilator patients shall be approved for payment above the ceilings as of the effective date of this plan. Ventilator patients that have their Medicaid eligibility canceled and later reinstated will no longer be "grandfathered in." Instead, they are considered to be new ventilator patients. 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 incremental costs of staffing and isolation supplies for AIDS patients, incremental costs of staffing for ventilator patients, and the cost of Medically fragile patients under age 21 who require skilled nursing care, shall be adjusted out based upon the flat rate payments made to the facility, in lieu of separately identifying actual costs. The cost of ventilators and related equipment shall be adjusted out based upon payments made to the facility, in lieu of separately identifying actual costs. Special billing procedures

shall be obtained by the provider from the Medicaid Office of Program Development. The class ceilings may also be exceeded in cases where Medicaid patients are placed by the Agency for Health Care Administration in hospitals or in non-Medicaid participating institutions on a temporary basis pending relocation to participating nursing homes, for example, upon closure of a participating nursing home. The HCFA Regional Office shall be notified in writing at least l0 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 6-month periods upon making a determination that a need for the exception still exists and upon providing the HCFA Regional Office with another advance written notification as stated above.

D. Effective October 1, 1985, FRVS shall be used to reimburse facilities for property. To prevent any facility 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.E.1.h. At that time, a facility shall begin reimbursement under the FRVS. Facilities entering the program after October 1, 1985 that had entered into an armslength (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.E.l.h.

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

l. 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 1 or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the 1 percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by the Agency in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report or 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 in those reports.
4. The section shall not apply to the case-mix adjustment calculated in Section V.G. of this plan.

F. The 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 Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology in Section V. of this plan.

G. Reimbursement of operating and patient care costs are subject to class ceilings. Property costs are subject to statewide ceilings, which shall be the ceilings computed at July 1, 1985, for facilities being reimbursed under Section III.G.3.-5. of this plan. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per Section V.E.1.g. of this plan. Return on equity and use allowance are passed through and are not subject to a ceiling.

H. An incentive factor is available to providers whose-operating per diems are under the class ceiling and who have provided quality of care resulting in standard ratings on the license issued by AHCA pursuant to the provisions of Rule 59A-4.128, F.A.C. Additional incentive is available for providers who have been granted superior quality of care licensure ratings. Beginning with the July 1, 1996, rate semester, incentive factor payments will no longer be made and a Medicaid Adjustment Rate shall be made pursuant to Section V.F. of this plan.

I. A low occupancy adjustment factor shall be applied to costs of certain providers.

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

l. 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 1 percent or more in the provider's total per diem reimbursement rate. For facilities 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 January 1 and July 1 of each year per Section V.E.1.j.

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 $5000 and would cause a change of 1 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 the Agency 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.

3. Interim rate requests resulting from 1., and 2. above must be submitted within 60 days after the costs are incurred, and shall be accompanied by a l2-month budget which reflects changes in services and costs. For providers being reimbursed under FRVS, interim rate adjustments due to capital additions or improvements shall be made per Section V.E.1.j. 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 received after August 3l, l984, the AHCA Office of Medicaid 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, the AHCA Office of Medicaid shall approve or disapprove the interim rate request within 60 days. If the AHCA office of 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 costs shall be paid to the provider.

5. Interim rates shall not be granted for fiscal periods that have ended.

K. The following applies to rate periods prior to July 1, 1985: In the event that a provider receives a new licensure rating making him eligible or ineligible for any amount of incentive payments, his prospective reimbursement rate shall be changed to reflect his new licensure rating and shall be effective beginning on the first day of the month after the month in which the new licensure rating became effective. For rates effective on or after July 1, 1985, the incentive payments based on licensure ratings shall be calculated according to the provisions of Section V.D. below.

L. Effective April 1, 1999 there will be a case-mix adjustment, which will be paid as an add-on to the patient care component of the provider's total reimbursement rate. The amount of the case-mix adjustment will be calculated pursuant to Section V.G. of this plan.

M. Aggregate Test Comparing Medicaid to Medicare 42 CFR 447.253(b)(2) (1994) provides that states must assure the Health Care Financing Administration that "The Medicaid agency's estimated average proposed payment rate...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 reimbursement principles, the following steps shall be taken for that rate semester, in order, as necessary 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 semester. 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, return on equity, taxes and insurance.
2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until 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 are implemented in order to meet the upper limit test, for a period of 1 year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

N. 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 the federal Health Care Financing Administration (HCFA). The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by HCFA.

V. Method

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

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January l and July l. The most current acceptable cost reports postmarked or accepted by a common carrier by September 30 or March 3l and received by October 15 or April l5, respectively, of each year and the provider's most recent reimbursement rates shall be used to establish the operating and patient care ceilings. More current cost reports shall be used to establish rates if production time permits. The first cost report submissions for all newly-constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end for these newly-constructed facilities must be after October l, l977. In addition, all facilities with year-ends prior to that of the one hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceiling. The ceiling for property computed here shall be used for all facilities not yet being reimbursed under FRVS. The ceiling computed at July 1, 1985 shall be used beginning with July 1, 1985 rates, and all subsequent rates for facilities until they begin receiving reimbursement under FRVS. For those facilities being reimbursed under FRVS, the cost per bed ceiling per Section V.E.1.g. of this plan shall be used.

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

   a. Size l-l00 beds - Northern Florida Counties

   b. Size l0l-500 beds- Northern Florida Counties

c. Size l-l00 beds - Southern Florida Counties

d. Size l0l-500 beds- Southern Florida Counties

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

Broward	Hardee-	Monroe
Charlotte	Hendry	Okeechobee
Collier	Highlands	Palm Beach
Dade	Indian River	Polk
Desoto	Lee	St. Lucie
Glades	Martin	Sarasota

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. Size 1-100 beds - Central Florida Counties

b. Size 101-500 beds - Central Florida Counties

The "Central Florida Counties: shall be comprised of :

Brevard	Manatee	Pinellas
Hardee	Orange	Polk
Highlands	Osceola	Seminole
Hillsborough	Pasco	

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.

4. Nursing homes participating in the Medicaid program as of July 1, 1994, and located in Hardee, Highlands, or Polk County, shall be "grand-fathered in," and shall be considered as members of the "Southern Florida Counties" class, until such time that the "Central Florida Counties" class reimbursement ceilings for the operating cost and patient care cost components equal or exceed the corresponding July 1, 1994, "Southern

Florida Counties" class ceilings. The "grandfathered-in" provision shall be applied separately for the operating cost and patient care cost components in each of the two facility size classes. That is, nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the operating cost component until such time as the "Central Florida Counties" operating cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" operating cost component ceiling for that class. Nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the patient care cost component until such time as the "Central Florida Counties" patient care cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" patient care cost component ceiling.

B. Setting prospective reimbursement per diems and ceilings. In determining the class ceilings, all calculations for Sections V.B. 1. - V. B. 18. shall be made using the four class, and "Northern Florida Counties" and "Southern Florida Counties" definitions of sections V.A. 2. above. All calculations for Sections V.B.19. - V.B.21 shall be made using the six class and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in A.l. 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 (1997)
3. Determine total allowable Medicaid cost.
4. Determine allowable Medicaid property costs, operating costs, patient care costs, and return on equity or use allowance. Patient 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, exclusive of property cost and return on equity or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K.

5. Calculate per diems for each of these four cost components by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.E. of this plan.

6. Adjust a facility's operating and patient care per diem costs that resulted from Step B.5 for the effects of inflation by multiplying both of these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Nursing Home Cost Inflation Index is displayed in Appendix A.

7. Adjust, for those facilities not being paid under FRVS, all four components of the per diem for low occupancy per a. through g. below. For those facilities being paid under FRVS, adjust the operating cost component, the patient care cost component, and the return on equity or use allowance cost component, but do not adjust the property component for low occupancy.

    a. Calculate the percentage of occupancy for each facility.

    b. Calculate the mean and the standard deviation of the distribution of occupancy levels obtained in 7.a.

c. Calculate the percentage of Medicaid days to total days for each facility ("percent Medicaid").

d. Calculate the mean and the standard deviation of the distribution of percent Medicaid obtained in 7.c.

e. Calculate the adjusted per diem components by multiplying each of the per diem components by the fraction: Individual facility occupancy level, divided by the statewide mean occupancy level less one standard deviation of occupancy levels from Step B.7.b.

f. The adjustment described in e. above shall not apply to:

l) Facilities with occupancy levels that exceed the statewide mean occupancy level less one standard deviation;

2. Facilities with only one cost report filed.

3) Facilities with a percentage of Medicaid days that exceeds the statewide mean less one standard deviation of the percentages of Medicaid days.

g. The occupancy adjustment for operating and patient care costs shall not result in a reduction of more than 30 percent of the applicable class ceiling. The property cost and return on equity or use allowance components shall be adjusted proportionately. The proportionate adjustment for the property and return on equity or use allowance per diems shall be made by multiplying each of those two per diems by the fraction:

The sum of the operating cost per diem, adjusted for occupancy, plus the patient care cost per diem, adjusted for occupancy; divided by the sum of the unadjusted operating cost per diem plus the unadjusted patient care cost per diem.

The property cost component shall not be subject to this low occupancy adjustment if a facility is being reimbursed under FRVS.

8. Determine the statewide property cost per diem ceilings for periods April 1, 1983 to July 1, 1985 as per a. through h. below.

   a. Calculate the per diem property cost for the array of newly-constructed facilities by dividing the total property cost by the total patient days for each facility.

   b. Calculate the statewide average occupancy for all facilities used in setting the patient care and operating ceilings. Calculate the median occupancy for the array of newly-constructed facilities.

   c. Calculate two occupancy-adjusted property per diems:

      (l) An average occupancy property per diem is calculated. The average occupancy property per diem equals the newly-constructed facility occupancy divided by the statewide average occupancy, times the newly-constructed facility property per diem.

      (2) A median occupancy property per diem for newly-constructed facilities is calculated as follows:
      The median occupancy property per diem equals the newly-constructed facility occupancy, divided by the median of newly-constructed facility occupancies, times the newly-constructed facility property per diem.

   d. Adjust the two occupancy-adjusted property per diems for the effects of construction cost inflation by multiplying each by the fraction: Florida Construction Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Construction Cost

Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Construction Cost Inflation Index is displayed in Appendix B.

e. Calculate the median and standard deviation of the distributions of average occupancy and median occupancy property per diems.

f. The statewide property cost per diem ceiling for facilities that have more than l8 months operating experience shall be the median of the average occupancy property per diems plus one standard deviation.

g. The statewide property per diem ceiling for facilities that have l8 or fewer months of operating experience shall be the median of the distribution of median occupancy property per diems plus one standard deviation. A facility which has more than 18 months operating experience shall be 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 of the original facility, limited by the lower property ceiling, multiplied by the ratio of its beds to total facility beds; and

2) Actual per diem costs of the addition, limited by the higher property ceiling, multiplied by the ratio of its 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.

h. Facilities that are not reimbursed based on FRVS shall be subject to the property cost ceilings calculated at July 1, 1985. New

property cost ceilings shall not be calculated at subsequent rate semesters.

9. Determine the median inflated operating and patient care costs per diems for each of the four-classes and for the whole State.

l0. For each of the per diems in 9. above, calculate the ratios for each of the four-class medians to the State medians.

ll. Divide individual facility operating cost per diems and patient care cost per diems that resulted from Step B.7. by the ratio calculated for the facility's class in Step l0.

l2. Determine the statewide median for the per diems obtained in Step B.ll.

l3. For each of the operating and patient care per diems, exclude the lower and upper l0 percent of the per diems of Step B.ll. and calculate the standard deviation for the remaining 80 percent.

l4. 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 patient care cost per diem as the sum of the median plus 1.75 standard deviations that resulted from Steps B.l2. and B.l3., respectively.

l5. Establish the cost based reimbursement ceilings for operating and patient care costs per diems for each class by multiplying the statewide ceilings times the ratios calculated for that class in Step B.l0.

16. Effective July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient cost in Step B.16 from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR), with the quantity:

$$1 + 1.4 \times \frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}} - 1$$

In the above calculation the 1.4 shall be referred to as the inflation multiplier.

For the January 1, 2000 rate semester only, the patient care component inflation multiplier in the above equation shall be adjusted upward for each provider until this adjustment in conjunction with the adjustment in B.17. c. results in an estimated additional reimbursement in the patient care component per B. 18. This adjustment in the inflation multiplier shall not result in a patient care per diem rate that exceeds the patient care per diem costs adjusted for inflation in Step B.6 or be less than a patient care per diem cost calculated using an inflation multiplier of 1.4.

17. Establish the reimbursement ceilings for operating and patient care cost per diems for each class as the lower of:

    a. The cost based class reimbursement ceiling determined in Step B.15.

    b. For rate periods beginning July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, the class reimbursement ceiling as calculated in B.17.b., from the previous rate semester, inflated forward with 1.4 (inflation multiplier) times the rate of increase in the Florida Nursing Home Cost Inflation Index through a calculation similar to that given in

Step B.16. No reimbursement ceiling can increase in excess of a 15 percent annual rate.

c. For the January 1, 2000 rate semester only, the 1.4 patient care component inflation multiplier shall be adjusted upward for each class ceiling until this adjustment in conjunction with the adjustment in B.16. b. results in an estimated additional reimbursement in the patient care component per B.18. The adjustment in the inflation multiplier shall not result in a patient care class ceiling that exceeds the class ceilings determined in Step B.15 or be less than the class ceiling calculated using an inflation multiplier of 1.4

18. The adjustments made to the patient care inflation multiplier in Sections I. B.1, V.B.16 and B.17. of this plan shall be made only when the January 1, 2000 rates are initially established and shall not be subject to subsequent revision. These adjustments shall result in an estimated additional reimbursement in the patient care component of $9,051,822 for the January 1, 2000 rate semester.

19. Establish the reimbursement ceilings for the operating and patient care cost per diems for the Size 1-100 bed "Central Florida Counties" and Size 101-500 beds "Central Florida Counties" classes as the arithmetic average of the reimbursement ceilings determined in Section V.B.17.

20. Compute the total cost-related per diem for a facility as the sum of:

a. The lower of the property cost per diem obtained in Step B.7. or the applicable statewide property cost per diem ceiling calculated in B.8., for facilities not reimbursed under FRVS. For those reimbursed under FRVS, substitute the FRVS rate calculated per Section E. below, which shall be the sum of the property tax (which excludes sales tax on lease payments) and insurance 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.

b. Return on equity per diem obtained in Step B.7.

c. Incentives for both the operating and patient care costs per diems obtained in Steps C. or D. below.

d. The lower of the operating cost per diem obtained in Step B.7, the operating target per diem obtained in Step B.16., or the applicable ceiling obtained in Step B.17.

e. The lower of the patient care cost per diem obtained in Step B.7, the patient care target per diem obtained in Step B.16., or the applicable ceiling obtained in Step B.17.

21. Multiply the sum of non-Medicare or Medicaid usual and customary charges by the inflation factor calculated in Step B.6. Divide the result by the total non-Medicare or Medicaid days.

22. Establish the prospective per diem for a facility as the lower of the result of Step B.19 or Step B.20.

C. Quality of care and cost containment incentives for rate periods during April 1, 1983 through June 30, 1985.

l. To encourage high-quality care while containing costs, this plan provides the following:

a) Providers who receive a "conditional" licensure rating shall receive no incentive for the duration of time that the conditional licensure rating is applicable.

b) Providers that receive a "standard" licensure rating may be eligible for an incentive. For any period during which a provider has an operating cost per diem from Step B.6. below the class ceiling, an incentive of 33.33 percent of the difference between the class ceiling and the operating cost per diem from Step B.6 shall be used in computing the provider's prospective per diem rate in Step B.19.c. This incentive shall not be greater than 20 percent of the class ceiling amount.

2. Providers with a "superior" licensure rating may be eligible for an incentive, in either the operating cost or patient care cost area or both, for the period of time during which they have a superior licensure rating. The incentives shall be determined as follows:

a) If the operating cost per diem from Step B.6 is below the class ceiling, an incentive of 66.67 percent of the difference between the class ceiling and the operating cost per diem from Step B.6 shall be used in computing the provider's reimbursement rate in Step B.19c. This incentive shall not be greater than 20 percent of the class ceiling.

b) If the patient care cost per diem from Step B.6 is below the class ceiling, an incentive of l0 percent of the difference between the class ceiling and the patient care cost per diem from Step B.6 shall be used in computing the provider's reimbursement rate in Step B. 19c. This incentive shall not be greater than 5 percent of the class ceiling.

D. Quality of care and cost containment incentives for rate periods beginning on or after July 1, 1985 through June 30, 1996.

1. To encourage high-quality care while containing costs, this plan provides for the following incentive payments. Incentives shall be paid for the current rate semester period based on a weighted average of the incentive amounts calculated using the licensure ratings that were in effect in the rate semester period 1 year prior. For operating costs, the operating cost per diem shall be less than the class ceiling and licensure ratings other than conditional shall have been received. For patient care costs, the patient care cost per diem shall be less than the class ceiling and a superior licensure rating must have been received.

2. The calculation of the per diem incentive amounts are as follows:

(a) Determine the number of days during the 6-month period 1 year prior to the rate semester for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

Example: For the rate semester January 1, 1986 through June 30, 1986, the 6-month period 1 year prior is January 1, 1985 to June 30, 1985. During that prior period, the provider's licensure ratings were:

RATING	PERIOD	DAYS
Superior	1/1/85 - 1/31/85	31
Conditional	2/1/85 - 3/31/85	59
Standard	4/1/85 - 6/30/85	91
		181

(b) For the rate periods beginning on or after January 1, 1988, if the lower of the operating cost per diem from Step B.6 and the operating target per diem from Step B.16. is less than the class

ceiling, calculate the positive difference. If the lower of the two per diems is greater than the ceiling, then skip c. through e. below.

(c) Multiply the difference in (b) above by the product of .6667 times the proportion of days in the period 1 year prior that a superior licensure rating was held. Using the example in (a) above, this product would be: (.6667) x (31/181). For rate periods beginning July 1, 1995, multiply the difference in (b) above by the product of .64 times the proportion of days in the period 1 year prior that a superior licensure rating was held. Using the example in (a) above, this product would be : (.64) x (31/181).

(d) Multiply the difference in (b) above by the product of 1/3 times the proportion of days in the period 1 year prior that a standard licensure rating was held. Example: (.3333) x (91/181). For rate periods beginning July 1, 1995, multiply the difference in (b) above by the product of .32 times the proportion of days in the period 1 year prior that a standard licensure rating was held. Example: (.32) x (91/181).

(e) Establish the weighted operating cost incentive per diem as the lesser of: the sum of the results of (c) and (d) above; or 20 percent of the class operating cost ceiling for rate periods prior to January 1, 1988, or 15 percent of the class operating reimbursement ceiling for rate periods beginning on or after January 1, 1988, or 10 percent of the class operating reimbursement ceiling for rate periods beginning on or after July 1, 1995.

(f) For rate periods prior to January 1, 1988, if the patient care cost per diem from Step B.6 is less than the class ceiling, calculate the

positive difference. If the patient care cost per diem is greater than the class ceiling, skip (g) and (h) below.

(g) Multiply the difference in (f) above by the product of (.1) times the proportion of days in the period one year prior that a superior licensure rating was held. Example: (.1) x (31/181).

(h) Establish the weighted patient care cost incentive as the lesser of: the result of (g) above; or 5 percent of the class patient care cost ceiling.

(i) Establish the total incentive payment as the sum of (e) and (h), if applicable.

(j) An example of the complete calculation is shown here, based upon the following information:

(1) Current rate semester period: January 1, 1986 to June 30, 1986;
Rate semester period 1 year prior:
January 1, 1985 to June 30, 1985;

(2) Licensure ratings in effect during January 1, 1985 to June 30, 1985:

RATING	PERIOD	DAYS
Superior	1/1/85 - 1/31/85	31
Conditional	2/1/85 - 3/31/85	59
Standard	4/1/85 - 6/30/85	91
		181

(3) The operating cost per diem is $3.00 below the class ceiling.

(4) The patient care cost per diem is $10.00 below the class ceiling.

The incentive for the current rate semester period, January 1, 1986 - June 30, 1986 is:

RATING:	**OPERATING**	
Superior	$3.00 x .6667 x 31/181=	$0.3426
Conditional	N/A x x 59/181=	N/A
Standard	$3.00 x .3333 x 91/181=`	.5027
Total Operating Incentive		$0.8453
RATING:	**PATIENT CARE**	
Superior	$10.00 x .1 x 31/181=	$0.1713
Conditional	N/A x 59/181=	N/A
Standard	N/A x 91/181=	N/A
Total Patient Care Incentive		$0.1713
Total Incentive		$1.0166

This total incentive of $1.0166 is added in the rate calculation in V.B.19.c.

(k) For rate periods beginning on or after January 1, 1988, calculate each facility's reimbursement rate for patient care costs as described in V.B. 19.e. Multiply this per diem by .03 times the proportion of days in the rate period one year prior that a superior licensure rating was held.

Example: (.03) X 31/181). The result of this calculation will represent the quality of care incentive to which the provider is entitled. This incentive is to be included in the provider's total reimbursement rate in place of the incentive determined in V.D.2.(h).

(l) For rate periods beginning on and after July 1, 1993, incentive payments shall be prorated based upon a facility's Medicaid utilization percentage, except as modified in (m) below. Facilities with 90% or greater Medicaid utilization shall receive 100% of their incentives. Facilities with 20% or less Medicaid utilization shall receive no incentives. Facilities between 20% and 90% Medicaid utilization shall have their incentives prorated by multiplying their incentives by the percentage calculated in the following formula:

$$100 \times \frac{[\text{Medicaid Utilization \% - 20\%}]}{70\%}$$

(m) For rate periods beginning July 1, 1995, facilities with 65% or less Medicaid utilization shall receive no operating incentives. Facilities between 65% and 90% Medicaid utilization shall have their operating incentives prorated by multiplying their operating incentives by the percentage calculated in the following formula:

$$100 \times \frac{[\text{Medicaid Utilization \% - 65\%}]}{25\%}$$

E. 1. FRVS for existing facilities at October 1, 1985.

a. Each 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 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 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 Medicaid reimbursement per HCFA-PUB.15-1 (1993) 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 excludes 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 6-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 DRI/McGraw - Hill Health Care Costs, Consumer Price Index All Urban All Items South Region shall be used.

FRVS rates shall be adjusted for inflation on each January 1 and July 1, using the change in the FCCI Index for the most recent 6-month period published prior to the rate semester. FRVS rates shall be adjusted per subsections f. and j. below for changes in interest rates on capital debt instruments and for capital additions or improvements on each January 1 and July 1. (See Appendix B for computation of the index).

b. A single FCCI Index, based upon the average of the Dodge Construction indicies for the six cities in Florida for which an index is published, shall be used through June 30, 1991 and the most recently published DRI Health Care Costs All Urban All Items South Region Index quarterly indices 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 3 percent semi-annual increase; however, during semesters when the increase in the index is greater than 3 percent, a credit, calculated as the actual increase minus 3 percent, shall be carried forward for future periods and added to the increase in the index, up to a maximum of 3 percent, when the actual future increases in the index are less than 3 percent. For example, if the increase in the index is 4 percent in Period 1, 3 percent shall be used and a credit of 1 percent shall be carried forward; then, if the increase in the index is 2 percent in Period 2, a 3 percent rate of indexing shall be used, by adding the 1 percent credit to the actual 2 percent increase. If more than 2 percent credits were available, a maximum of 3 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 3 percent. 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 3 percent 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: 1/10 in year 1, 2/10 in year 2, 3/10 in year 3, up to 10/10 in year 10. The total percent increase allowed for any 6-month rate semester shall not exceed 3 percent. For the second 10 years, the unadjusted index increase shall be used, subject to a 3-percent semi-annual limitation. For the next 20 years, years 20 through 40, a straight-line decreasing portion of the allowable increase in the index shall be used subject to the 3-percent limit per rate semester: 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.

d. For rate semesters beginning on or after January 1, 1986, an adjustment shall be made in indexing for failure of a licensure re-inspection and for low Medicaid utilization.

(1) Any facility which receives a conditional licensure rating and upon re inspection has not corrected deficiencies as required by the AHCA Office of Licensure and

Certification, shall receive no indexing in the FRVS rate for the 6-month rate period subsequent to the re inspection.

(2) Medicaid utilization shall be calculated as 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 semester. 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 Medicaid utilization. The adjustment for fiscal years ending in 1980 or after shall be computed as follows: if the provider's cost report or budget shows less than 25-percent average Medicaid utilization for the cost reporting period, then no indexing of asset valuation shall be given; if 25 percent to 55 percent Medicaid utilization is computed, then the portion of the FCCI Index increase calculated in subsection 1.c. above shall be multiplied by the fraction equal to the actual utilization percent divided by 55 percent; if 55 percent or greater Medicaid utilization is computed, then full indexing using the portion of the FCCI Index increase calculated in subsection 1.c. above shall be given.

e. The asset valuation of the facility shall be indexed, according to 1.a.-1.d. above, from the date of entry into the Medicaid program, but not prior to January 1, 1972, to October 1, 1985. That asset valuation, subject to the cost per bed ceiling in g. below, shall be

used to initiate 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: 80 percent of the total asset valuation shall be amortized over 20 years, at the interest rate specified in f. below, to determine an amount which would pay principal and interest on an installment mortgage for that 80 percent of the asset valuation. For facilities beginning FRVS with a total initial principal balance of all current mortgages less than 60 percent of the indexed asset value, only the interest portion will be used in calculating the FRVS rate. The calculated 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 newly-constructed facilities, the 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 facilities that have put into service new beds for the first 12 months, the 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:

1) The ratio of the new beds to total facility beds multiplied by 75 percent; and

2) The ratio of existing beds prior to the addition to total facility beds multiplied by 90 percent.

Property taxes (which excludes sales tax on lease payments) and insurance shall have a per diem calculated based upon actual historic cost and patient days as shown in the latest applicable cost report. Twenty percent of the asset valuation shall be used to calculate a return on equity for property-related equity per sections III.J. and K., and this return on equity shall be included as part of the FRVS rate. This will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility and by 75 percent of the maximum annual bed days for newly constructed facilities. Again, for those 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 twenty 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 explained in 1) and 2) above.

f. (1) The interest rate used to amortize the 80 percent component of the asset valuation shall be the lower of: the owner's actual mortgage rate; the Chase Manhattan Bank's prime rate as of the date of the provider's loan commitment plus 2 percent for a variable-rate mortgage or plus 3 percent for a fixed mortgage rate; or 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.

(2) 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) below. For variable-rate mortgages, no changes shall be made unless the owner's interest rate changes according to (3) below.

(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%) at June 30, 1996, (referenced above) beginning with the July 1, 1996, rate semester, these same providers shall have 12.5% used for the “lesser of” comparison on and after July 1, 1996. For rate semesters prior to July 1, 1996, these same providers shall remain at 13%. Providers shall be required to notify the Agency of their mortgage rate and any changes in their mortgage rate. 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. At that time, the FRVS rate to be used for the next 6-month rate semester beginning January 1 or July 1 shall be determined using the most current mortgage rate, but not to exceed the October

15 or April 15, respectively, Chase-Manhattan prime plus 2 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 as detailed above, 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 semester shall be calculated using the interest rate per (1) above.

(5) An increase in the interest rate shall be allowed only if refinancing was necessary in order to finance the addition of new beds or 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 (1) above based upon mortgage amounts and interest rates of the various mortgages.

g. The standard, or ceiling, per-bed cost shall be established at $28,500.00 at October 1, 1985. Each existing facility at October 1, 1985, shall have its total capital assets valuation limited to that standard or the facility's computed asset valuation, whichever is less. The standard of $28,500.00 shall be indexed forward every 6 months based upon the most recently published 6-month full 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 6 months prior to the date the facility was first put into service as a nursing home. 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 Medicaid program at October 1, 1985, do not receive reimbursement for property and return on equity or use allowance under the FRVS method less than the property cost reimbursement plus return on equity or use allowance given at September 30, 1985. If, after calculation of the FRVS rate, that reimbursement would be lower than depreciation plus interest costs under III.G. 3.-5. of this plan, a facility shall continue to be reimbursed depreciation plus interest according to III.G. 3.-5. of this plan until such time as the net difference in total payments between III.G. 3.-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 the Agency in writing by December 2, 1985. Facilities with existing

leases at October 1, 1985, shall be paid at the September 30, 1985 rate subject to III.G.2. until the current lease expires, at which time reimbursement shall begin under FRVS based on the owner's acquisition costs. Providers shall supply the Agency 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 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. of this plan.

i. Facilities existing and enrolled in the Medicaid program at October 1, 1985, shall be phased up to their FRVS rate in equal percent increments based upon the following schedule:

YEAR OF ENTRY INTO MEDICAID PROGRAM	YEARS TO FULL FAIR RENTAL VALUE FROM OCTOBER 1, 1985
December 31, 1971 or earlier	4
1972	5
1973	6
1974	7
1975	8
1976	8
1977	9
1978	9
1979	10
1980	10
1981	10
1982	10
1983	10
1984	10
January 1, 1985 through September 30, 1985	10
October 1, 1985 and after	-0-

FRVS rates shall be calculated according to subsections a. through g. above, but actual payments made during the applicable years of phase-in starting at October 1, 1985 shall be limited to the reimbursement rate effective as of September 30, 1985, exclusive of property taxes and insurance, plus a portion of the difference between that rate and the newly-computed FRVS rate. The portion of the difference allowed shall be a function of the number of years applicable to attaining full FRVS as shown above for various facility entry dates. A facility with a 4-year phase-in shall receive payments based on one-fourth of the difference for rates at October 1, 1985, January 1, 1986, and July 1, 1986; two-fourths of the difference for rates at January 1, 1987 and July 1, 1987; three-fourths of the difference for rates at January 1, 1988 and July 1, 1988; and four-fourths of the difference for rates at January 1, 1989 and thereafter. Similarly, a facility with an 8-year phase-in shall receive payments based on one-eighth of the difference for rates at October 1, 1985, January, 1, 1986 and July 1, 1986; two-eighths of the difference at January 1, 1987 and July 1, 1987; and so on, until attaining eight-eighths of the difference for rates at January 1, 1993 and after.

j. Subsequent to October 1, 1985, no adjustments to asset valuation shall be made for replacements of existing equipment for those facilities fully phased to FRVS payments. 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 g. above that is in effect 6 months prior to the date the facility addition was first put in service as a nursing home. 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 semester. 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 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 semester or in any rate semester 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)(a) Effective July 1, 1996, providers whose indexed asset valuation exceeded 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.

(1)(b) Providers that entered into a legally enforceable arms 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, arms length agreement must be submitted with the cost report in which the additions or improvements are reported.

(2) In no other circumstances other than in (1)(a) and (1)(b) above shall a provider's total asset value under FRVS exceed their current per bed standard.

(3) 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. For facilities with 5 to 10 years remaining to full FRVS phase-in, 50 percent of replacement cost shall be reimbursed as a pass-through cost as depreciation and interest expense; if 4 years are remaining in the phase-in, 40 percent; if 3 years remaining, 30 percent; 2 years remaining, 20 percent; and 1 year remaining, 10 percent. This pass-through

reimbursement shall be recaptured by AHCA in entirety if the facility undergoes a change of ownership.

2. FRVS for facilities entering the Medicaid program subsequent to October 1, 1985.

   a. The FRVS rate for facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Medicaid program subsequent to October 1, 1985 shall be calculated as in 1.a.-h. and j. above. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under Section III. G. 2. - 5.

   b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect 6 months prior to the date the facility was first put into service as a nursing home. 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 6 months prior to the date the facility was first put into service as a nursing home.

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

   a. Facilities that participate in the 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 E.1.c. above 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 the Agency'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. below, the new provider's reimbursement shall be based on 1.-3. above.

b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of 1.h. above, the new owner shall also receive depreciation plus interest per Section III.G. unless he requests the Agency, 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 1.f. above.

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 that 60 percent of the indexed asset value, only the interest portion, at a rate determined in 1.f.(4), 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 1.f.(1) above. 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 1.f.(1). above. Any credits accrued by the previous owner for indexing as described in 1.b. above shall be applied to the new owner.

d. The return on equity or use allowance shall be calculated as per 1.e. above. A per diem shall be calculated for property taxes and insurance, based

upon actual historic cost and patient days shown in the latest applicable cost report, as per 1.e. above.

e. The new provider shall be subject to the recapture provisions in Section III.H. of this plan. The new provider's cost basis shall be computed per III.G.3. of this plan.

f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider. The new provider shall enter the phase-in schedule at the point reached by the previous provider at the change of ownership, and shall be reimbursed per 1.j. above for replacement costs.

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 Medicaid certification effective on or after July 1, 1991.

	Example 1	Example 2
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

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 Medicaid allowable cost.

F. Medicaid Adjustment Rate (**MAR**)

For rate periods beginning on and after July 1, 1996, the Medicaid Adjustment Rate shall be calculated as follows:

1. Facilities with 90% or greater Medicaid utilization shall have their MAR equal their WBR as determined in the formula below.
2. Facilities with 50% or less Medicaid utilization shall receive no MAR.
3. Facilities between 50% and 90% Medicaid utilization shall have their MAR as determined by the following formula:

MAR = **WBR** x **MA**
WBR = **(BR x MAW)** X ((**Superior** + **Standard**)/**All**).
MA = ((Medicaid Utilization % - **MIN**)/(**MAX-MIN**)) X 100

Definitions:

MAR = Medicaid Adjustment Rate
WBR = Weighted Base Rate
MA = Medicaid Adjustment
BR = Base Rate, which is set as the results of step V.B.19.e
MAW = Medicaid Adjustment Weight, which is set at .045
Superior =Number of Superior Days as described in section V.D.2.(a)
Standard = Number of Standard Days as described in section V.D.2.(a)
All = All superior, standard, and conditional days
MIN = Minimum Medicaid Utilization Amount which is set at 50%
MAX = Maximum Medicaid Utilization Amount which is set at 90%

The result of these calculations will represent the **MAR** to which the provider is entitled. This rate is to be included in the patient care component of the provider's total reimbursement rate.

G. Case-Mix Adjustment

For the rate period beginning on April 1, 1999 through June 30, 1999 and for rate periods beginning on and after July 1, 1999, a case-mix adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate.

A. 1. AHCA will utilize the Minimum Data Set (MDS) Assessments being submitted by nursing facilities to calculate an average case-mix score for each nursing facility participating in the Medicaid program. The average case-mix score will be computed by using the most current version Resource Utilization Grouper (RUGS III), as published by HCFA, to classify the MDS assessments into one of thirty-four (34) RUGS III categories. An additional category will be added as a default, which will be assigned the lowest case-mix weight, for those MDS assessments that can not be classified. For purposes of calculating the case-mix score only MDS assessments for Medicaid residents will be utilized to establish the average case-mix score.

a. For the rate period April 1, 1999 through June 30, 1999 the MDS assessments filed for the period October 1, 1998 through February 28,1999 will be used to calculate the average case-mix score. For each July 1 and January 1 rate period subsequent to June 30, 1999 the MDS assessments submitted for the periods October 1 through March 31 and April 1 through September 30, respectivelywill be used in the calculation of the average case-mix score.

b. For the applicable periods as described in Section V.G.1.a. above a case-mix score will be calculated for each MDS assessment submitted for a Medicaid resident. The total case-mix score for each resident will be weighted by the number of days covered by the MDS assessment. Upon computing each individual's weighted case-mix score an average case-mix score will be computed for the facility using all Medicaid residents.

c. An average case-mix score will be calculated for all nursing facilities participating in the Medicaid program as of April 15 and October 15 preceding the July 1 and January 1 rate semesters, respectively. New providers, as defined in V.G.1.d. below, entering the Medicaid program

subsequent to the April 15 and October 15 dates will not receive a case-mix adjustment until the following January 1 and July 1 rate semesters, respectively. For the rate period April 1, 1999 through June 30, 1999 only those nursing facilities participating in the Medicaid program as of February 28, 1999 will receive a case-mix adjustment to the patient care component of their total reimbursement rate.

d. For new providers entering the Medicaid program the average case-mix score will be the minimum established under Section V. G. 2.a.below. New providers, for purposes of calculating the case-mix adjustment, are those in a newly constructed nursing facility or nursing facilities which have not previously participated in the Medicaid program. For existing providers undergoing a change in ownership or operator the MDS assessments submitted for the previous Medicaid provider will be used to establish the average case-mix score for the new provider.

e. No changes or corrections to the case-mix adjustment paid to a nursing facility will be made subsequent to the effective date of the case-mix adjustment.

2. The case-mix adjustment to the patient care component of the total per diem rate will be calculated using the following methodology.

a. Upon calculating the average case-mix score for each nursing facility eligible for the case-mix adjustment, a statewide average case-mix score will be computed. The statewide average case-mix score will be the average case-mix score for all facilities eligible for the case-mix adjustment. The lowest case-mix score will be used as the minimum score for new providers, as described in V.G.1.d. above.

b. An average case-mix rate will be used to calculate each facility's add-on and will be calculated by dividing the available dollars appropriated for the

case-mix adjustment by the projected number of Medicaid days in the prospective rate period. For the April 1, 1999 case-mix adjustment the prospective period will be April 1, 1999 through June 30, 1999.

c. The add-on for each individual facility will be computed by multiplying the average case-mix rate determined in Section V.G.2.b. above times each facility's average case-mix score in Section V.G.2.a. above divided by the statewide average case-mix score, calculated in Section V.G.2.a. above.

d. If in total the add-on for each facility times that facility's projected Medicaid days does not equal the total funds appropriated for the case-mix add-on, then each facility's add-on will be proportionately adjusted to ensure that total payments for the case-mix add-on equals the available funds.

H. Direct Care Staff Adjustment (DCSA)

Effective April 1, 2000, a direct care staff adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate. The Agency is to reimburse those nursing facilities who qualify and choose to receive the adjustment for the cost of hiring additional certified nursing assistants and licensed nurses or for the cost of salary or benefit enhancements to retain such staff in these specific classes.

1. The qualification criteria used to determine if a provider participates in the distribution of the DCSA includes the following:

   a. The provider must be an active Medicaid provider and submit direct care staffing, patient day and cost data for the base period of January 1, 1999 through June 30, 1999.

b. The provider must notify the Agency of its intent to participate in the DCSA.

c. The provider must submit a statement of how it intends to meet legislative intent in spending the DCSA.

d. The provider must agree to provide follow-up documentation as described in Section 4 below.

2. The direct care staffing ratios shall be calculated and ranked as follows:

a. From the data received for the period January 1, 1999 through June 30, 1999, the total direct staffing hours per patient day is calculated for CNAs and licensed nurses for each provider.

b. The direct care staffing ratios calculated in subsection a above are ranked from high to low.

3. The DCSA shall be calculated as follows:

a. The total annualized Medicaid days for participating providers is projected from the six-month reporting period in Section 1a above.

b. The annualized Medicaid days are multiplied by a $0.50 minimum add-on to determine the minimum amount that a provider will receive. The total minimum add-on amount for all providers is calculated.

c. The remaining amount to be allocated is calculated by subtracting the total minimum add-on calculated in subsection b above from the total amount of the DCSA.

d. All providers with a direct care staffing ratio of 5 or above will be assigned the value of 5 and will only receive the minimum amount in subsection b above.

e. All providers with a direct care staffing ratio of 2.3 or below will be assigned the value of 2.3 and will receive the maximum add-on amount available under this methodology.

f. To achieve an inversely proportionate distribution, each provider's staffing ratio is subtracted from the assigned value of 5, from subsection d above, to calculate an inverted hours per patient day. This results in providers with a lower staffing ratio receiving a higher result (e.g., 5-2.3=2.7) and providers with a higher staffing ratio receiving a lower result (e.g., 5-5=0).

g. For each provider, the Medicaid patient days are multiplied by the inverted hours per patient day as calculated in subsection f above, to arrive at a unadjusted additional add-on amount.

h. The amount calculated in subsection g above for each provider is adjusted proportionately so that the total amount for all providers equals the remaining amount to be allocated in subsection c above.

i. Each provider receives a total DCSA which includes the minimum amount in subsection b above plus the remaining amount in subsection h above.

j. No changes or corrections to the data used to calculate the DCSA shall be made subsequent to the effective date of the DCSA except as noted in sections 4 and 5 below.

4. All providers receiving a DCSA must provide documentation of direct care expenditures during the period May 1, 2000 through October 31, 2000 to demonstrate adherence to legislative intent. This documentation must be submitted to the Agency by November 30, 2000 and in a format similar to the base data period documentation. Any amount deemed not to have been appropriately expended is to be reimbursed back to the Agency.

5. When prospective rates are based on cost reports that include any of the additional costs associated with the DCSA, an appropriate adjustment to the patient care component of the per diem rate shall be made to prevent duplicative reimbursement.

VI. Payment Assurance

The State shall pay each nursing home for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59, F.A.C., 42 CFR (1997), and Section 1902 of the Social Security Act. The payment amount shall be determined for each nursing home according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of nursing homes in the Medicaid Program, the availability of high-quality nursing home services for recipients, and for services, which are comparable to those available to the general public.

VIII. Payment in Full

Any provider participating in the Florida Medicaid nursing home program who knowingly and willfully charges, for any service provided to the patient 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 patient as a condition of admitting a patient to a nursing facility or intermediate care 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 Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15 (1997).

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.

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

Audit: Means a direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

Audit Adjustment: Means any adjustment within the Medicaid audit report or Medicaid desk review report on Attachment A.

Audit Finding: Means any adjustment within the Medicaid audit report or Medicaid desk review report not listed on Attachment A.

Desk Review: Means an examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from the AHCA reviewer's office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

District: The agency shall plan and administer its programs of health, social, and rehabilitative services through service districts and subdistricts composed of the following counties:

District 1 - Escambia, Santa Rosa, Okaloosa, and Walton counties

District 2, Subdistrict A - Holmes, Washington, Bay, Jackson, Franklin, and Gulf counties

District 2, Subdistrict B - Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor counties

District 3, Subdistrict A - Hamilton, Suwanee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, and Alachua counties

District 3, Subdistrict B - Marion, Citrus, Hernando, Sumter, and Lake counties

District 4, Subdistrict A - Baker, Nassau, Duval, Clay, and St. Johns counties

District 4, Subdistrict B - Flagler and Volusia counties

District 5 - Pasco and Pinellas counties

District 6, Subdistrict A - Hillsborough and Manatee counties

District 6, Subdistrict B- Polk, Hardee and Highlands counties

District 7, Subdistrict A - Seminole, Orange, and Osceola counties

District 7, Subdistrict B - Brevard county

District 8, Subdistrict A - Sarasota and Desoto counties

District 8, Subdistrict B - Charlotte, Lee, Glades, Hendry and Collier counties

District 9 - Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach counties

District 10 - Broward county and

District 11 - Dade and Monroe counties

HCFA-PUB.l5-1: Health Insurance Manual No. l5, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

Medicaid Interim Reimbursement Rate: A reimbursement rate or component of an overall reimbursement rate that is calculated from budgeted cost data. Any overpayments or under payments resulting from the difference between budgeted costs and actual costs (limited by class or statewide ceilings), as determined through an audit of the same reporting period, will be either refunded to the Agency or paid to the provider as appropriate.

Medically Fragile: Infants and children with complex medical problems are individuals, ages 0-21, who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hour a day medical/nursing/health supervision or intervention. Medically fragile means an individual whose medical condition is such that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN) or is ventilator dependent.

Medicaid Nursing Home Operating Costs: Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

Medicaid Nursing Home 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.

Medicaid Nursing Home Property Costs: Those costs related to the ownership or leasing of a nursing home. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Provider: Means 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.

Reimbursement Ceilings: The upper rate limits for Medicaid nursing home operating and patient care reimbursement for nursing homes in a specified reimbursement class, or, the upper limit for nursing home property cost reimbursement for all nursing homes statewide.

Reimbursement Ceiling Period: January 1 through June 30 of a given year or July 1 through December 31 of a given year.

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).

APPENDIX A
CALCULATION OF THE FLORIDA NURSING HOME COST INFLATION INDEX

Based on a sample size of approximately 25% of the cost reports filed for the rate period beginning January 1, 1988, the percentage weights for cost components are estimated as:

Salaries and Benefits	57.89%
Dietary	5.18%
Others	36.93%

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

Component	DRI Index
Salaries and Benefits	Wages and Salaries, combined with Employee Benefits
Dietary	Food
All Others	Fuel and Utilities, combined with Other Expenses

The DRI indices are combined by summing the products of each index times the ratio of the respective DRI budget share to total budget share represented by the combined indices. Example: For the fourth quarter of 1982 Health Care Costs (April, 1982 issue, p. 18)

Wages and Salaries index = 1.026; budget share = .595
Employee Benefits index = 1.062; budget share = .089
Weighted combination (Salaries and Benefits)
= (1.026 x (.595/(.595+.089))) + (1.062 x (.089/(.595+.089)))
= 1.03068

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

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Quarter	Index	Average Index	Corresponding Month
1982: 1	0.9908	0.9954	March 31
1982: 2	1.0000	1.0078	June 30
1982: 3	1.0l55	1.0236	September 30
1982: 4	1.0316		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.0078/.9954)$^{1/3}$ x .9954
= .9995

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.0078/.9954)$^{2/3}$ x .9954
= 1.0036

All monthly indices can be calculated in a similar fashion.

These indices will be updated semi-annually prior to each January l and July l. Weights for cost components will be updated based on the latest available cost data on file with AHCA.

APPENDIX B
CALCULATION OF THE FLORIDA CONSTRUCTION COST INFLATION INDEX
FOR RATES EFFECTIVE PRIOR TO 7/1/91

The Florida Construction Cost Inflation Index is calculated by combining certain indices in the semiannual quarterly publication, Dodge Building Cost Indices for U.S. & Canadian Cities, published by McGraw-Hill. The Florida Index is calculated by the following steps:

l. Compute the average Dodge Index for the six Florida cities listed in the publication: Fort Myers, Jacksonville, Miami, Orlando, Tallahassee, and Tampa.

2. The combined Florida Construction Cost Inflation Index from Step l is projected one semester forward by assuming that the change in the index over the six months will equal the change in the last six months. Thus:

Projected Index Value =
Last Index Value / Next-to-last Index Value x Last Index Value

For example, the March 1984 average value is 1700.02 and the September l983 average value is 1688.27 (using the March l984 publication), so that:

Projected March l984 value = $\frac{1700.02}{1688.27} \times (1700.02) = 1711.85$

3. The semiannual index values obtained in Steps 1 and 2 are used to obtain monthly Florida Construction Cost Index values. The monthly index value m months past the previous index is computed as follows:

Monthly Value
m Months Past = Previous Index
$\left(\frac{\text{Next Index Value}}{\text{Previous Index Value}}\right)^{m/6} \times$ Previous Index Value

For example, using the September 1983 and March 1984 values given above, the interpolation formula yields

October 1983 Index = $1700.02^{1/6} \times 1688.27 = 1690.22$

November 1983 Index = $\frac{1700.02^{2/6}}{1688.27} \times 1688.27 = 1692.17$

These indices will be updated semi-annually prior to each January 1 and July 1 using the most recent publication of the Dodge Indices.

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FOR RATES EFFECTIVE ON AND AFTER 7/1/91

The Florida Construction Cost Inflation Index is calculated from Health Care Costs published by DRI/McGraw-Hill using the CPI All Urban All Items Regional Index for the South Region. The Florida Index is calculated by the following steps:

1. Using the most recent Health Care Costs publication, locate the tables containing the Consumer Price Index All Urban 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 semester.

Example:

Rate Semester - January 1991

Publication - DRI/McGraw-Hill Health Care Costs, Third Quarter 1990, Page 18, Table 6.

Quarter	Index	Average Index	Corresponding Month
1991:2	1.041	1.0345	March 31
1991:1	1.028		
1990:4	1.014	1.007	September 30
1990:3	1.000		

6 month inflation multiplier =
(1.0345/1.007) =
1.027308 or
2.7308 % increase over 6 months.

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