TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #06-157(F)

DIGEST

Amends 405 IAC 1-12-2, 405 IAC 1-12-5, 405 IAC 1-12-7, 405 IAC 1-12-9, 405 IAC 1-12-12, 405 IAC 1-12-15, 405 IAC 1-12-16, 405 IAC 1-12-19, and 405 IAC 1-12-22 and adds 405 IAC 1-12-20.5 to revise the Medicaid reimbursement methodology for nonstate owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) to permit reimbursement for residences for adults with extensive support needs. Effective 30 days after filing with the Publisher.

405 IAC 1-12-2; 405 IAC 1-12-5; 405 IAC 1-12-7; 405 IAC 1-12-9; 405 IAC 1-12-12; 405 IAC 1-12-15; 405 IAC 1-12-16; 405 IAC 1-12-19; 405 IAC 1-12-20.5; 405 IAC 1-12-22

SECTION 1. 405 IAC 1-12-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-2 Definitions

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

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate ~~which,~~ **that,** at a minimum, reimburses for all nursing or resident:
(1) care;
(2) room and board;
(3) supplies; and ~~all~~
(4) ancillary services;
within a single, comprehensive amount.

(c) "Allowable cost determination" means a computation performed by the office or its contractor to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.

~~(e)~~ **(f)** "Annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule, which shall constitute a comprehensive basis of accounting.

~~(f) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.~~

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked

in numerical order based on the allowable resident-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 16(a) of this rule.

~~(g)~~ **(h)** "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall **be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1 and shall** be computed on a statewide basis for like levels of care, with the ~~exception~~ **exceptions** noted in this subsection, ~~and shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1.~~ **as follows:**

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing.

(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.

(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental ~~increased~~ **homes multiplied** by one hundred fifty-nine percent (159%).

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

~~(h)~~ **(i)** "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

~~(i)~~ **(j)** "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

~~(j)~~ **(k)** "CRF/DD" means a community residential facility for the developmentally disabled.

~~(k) "DDARS"~~ **(l) "DDRS"** means the Indiana division of disability ~~aging,~~ and rehabilitative services.

~~(l)~~ **(m)** "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

~~(m)~~ **(n)** "Desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

~~(n)~~ **(o)** "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year-end.

(p) "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

~~(o)~~ **(q)** "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

~~(p)~~ **(r)** "Forms prescribed by the office" means:

(1) forms provided by the office; or
(2) substitute forms ~~which~~ **that** have received prior written approval by the office.

~~(q)~~ **(s)** "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

~~(r)~~ **(t)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(s)~~ **(u)** "ICF/MR" means an intermediate care facility for the mentally retarded.

~~(t)~~ **(v)** "Like levels of care" means **care:**
(1) ~~care~~ within the same level of licensure provided in a CRF/DD; or
(2) ~~care~~ provided in a nonstate-operated ICF/MR.

~~(u)~~ **(w)** "Non-rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:
October 1, 2003, through September 30, 2004
October 1, 2005, through September 30, 2006
October 1, 2007, through September 30, 2008
October 1, 2009, through September 30, 2010
And every second year thereafter.

~~(v)~~ **(x)** "Office" means the Indiana office of Medicaid policy and planning.

~~(w)~~ **(y)** "Ordinary patient or resident-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

~~(x)~~ **(z)** "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

~~(y)~~ **(aa)** "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

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

~~(aa)~~ **(cc)** "Rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:
October 1, 2002, through September 30, 2003
October 1, 2004, through September 30, 2005
October 1, 2006, through September 30, 2007
October 1, 2008, through September 30, 2009
And every second year thereafter.

~~(bb)~~ **(dd)** "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies.

~~(cc)~~ **(ee)** "Routine medical and nonmedical supplies and equipment" includes those items generally required to

assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

~~(dd)~~ **(ff)** "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

~~(ee)~~ **(gg)** "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, **for all providers, except for providers of extensive support needs residences for adults.**

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 2. 405 IAC 1-12-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or

(2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the certification date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/MR providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) **Until the identified threshold number of homes is obtained, the fiftieth percentile rates shall be determined as follows:**

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing.

(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.

(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental ~~increased~~ **homes multiplied** by one hundred fifty-nine percent (159%).

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences for adults, the fiftieth percentile rate for extensive support needs residences for adults shall be the fiftieth percentile rate for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation

until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year-end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

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

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and ordinary charge.
(8) Certification by the provider that:
  (A) the data are true, accurate, and related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123; filed Oct 10, 2002, 10:52 a.m.: 26 IR 721; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 3. 405 IAC 1-12-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

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

Sec. 7. (a) Rate setting during rebasing years shall be based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs during rebasing years, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

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

(c) For ICFs/MR and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ICFs/MR and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule **for all providers, except for providers of extensive support needs residences for adults.**
(5) The fair rental value allowance determined in accordance with section 20.5 of this rule for providers of extensive support needs residences for adults.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 723; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 4. 405 IAC 1-12-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office

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

Sec. 9. During rebasing years and for base rate reviews, the Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate established during rebasing years and for base rate reviews is subject to the following ~~four (4)~~ limitations:

(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the ~~DDARS.~~ **DDRS.**

(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.
(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.
(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I
Profit Add-On

The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.

Level of Care	(A) Percent	(B) Ceiling	(C) Cap
Sheltered living	40%	105%	10%
Intensive training	40%	120%	10%
Child rearing	40%	130%	12%
Nonstate-operated ICF/MR	40%	125%	12%
Developmental training	40%	110%	10%
Child rearing with a specialized program	40%	120%	12%
Small behavior management residences for children	40%	120%	12%
Basic developmental	40%	110%	10%
Small extensive medical needs residences for adults	40%	110%	10%
Extensive support needs residences for adults	**40%**	**110%**	**10%**

TABLE II
Overall Rate Limit

Level of Care	(A) Percent
Sheltered living	115%
Intensive training	120%
Child rearing	130%
Developmental training	120%
Child rearing with a specialized program	120%
Small behavior management residences for children	120%
Basic developmental	120%
Small extensive medical needs residences for adults	120%
Extensive support needs residences for adults	**120%**
Nonstate-operated ICF/MR	107%

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-9; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2320; filed Aug 15, 1997, 8:47 a.m.: 21 IR 79; filed Oct 31, 1997, 8:45 a.m.: 21 IR 951; filed Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Oct 10, 2002, 10:52 a.m.: 26 IR 724; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 5. 405 IAC 1-12-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-12 Allowable costs; capital return factor

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

Sec. 12. (a) Providers, **other than extensive support needs residences for adults,** shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient or resident care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate during rebasing years is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient or resident care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-12; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 724; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 6. 405 IAC 1-12-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

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

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition, **for all providers, except for providers of extensive support needs residences for adults,** shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000

3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

The schedule shall be updated semiannually effective on March 1 and September 1 by the office and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate, **for all providers, except for providers of extensive support needs residences for adults,** that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor, which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on **the following:**

(A) The maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date.

(B) The term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983. ~~and~~

(C) The allowable interest rate is the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on **the following:**

(A) The allowable equity as established under section 14 of this rule. ~~and~~

(B) The rate of return on equity is the greater of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be ~~no~~ **not** greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program, shall not be recognized as an allowable cost:

(1) Legal fees.
(2) Accounting and administrative costs.
(3) Travel costs.
(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-15; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2324; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 726; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 7. 405 IAC 1-12-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 16. (a) The basis used in computing the capital return factor **and the average historical cost of property of the median bed** shall be the historical cost of all assets used to deliver patient or resident-related services, provided ~~the following:~~ **they are:**

(1) ~~They are~~ in use;

(2) ~~They are~~ identifiable to patient or resident care;

(3) ~~They are~~ available for physical inspection; **and**

(4) ~~They are~~ recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost and any associated property **financing or** financings or capital **lease or** leases shall not be included in computing the capital return factor **or the average historical cost of property of the median bed.**

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor **and the average historical cost of property of the median bed** shall include only items currently used in providing services customarily provided to patients or residents.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's length sale or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-16; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 727; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 8. 405 IAC 1-12-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided ~~such~~ **the:**

(1) employees are engaged in patient or resident care-related functions; and ~~that~~

(2) compensation amounts are reasonable and allowable under this section and sections 20 through 22 of this rule.

(b) The provider shall report using the forms or in a format prescribed by the office all patient and resident-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when ~~such~~ **the** services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. **For all providers, except for providers of extensive support needs residences for adults:**

(1) hours for laundry services in CRF/DD or ICF/MR facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility; **and**

(2) hours associated with the provision of day services and other ancillary services, except as specified in subsection (d), shall be excluded from the staffing limitation.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-19; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 729; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 9. 405 IAC 1-12-20.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-12-20.5 Extensive support needs residences for adults; fair rental value allowance

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

Sec. 20.5. Providers of extensive support needs residences for adults shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility. The fair rental value allowance shall be calculated as follows:

(1) The fair rental value allowance for extensive support needs residences for adults is calculated during rebasing years and base rate reviews by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including the following:

(A) Land.
(B) Building.
(C) Improvements.
(D) Vehicles.
(E) Equipment.

The original historical cost of allowable resident related land, buildings, and improvements as of the provider's date of initial Medicaid certification shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined in subsection (1) *[subdivision (1)]* is arrayed to arrive at the average historical cost of property of the median bed.
(3) The average historical cost of property of the median bed as determined in subsection (2) *[subdivision (2)]* is extended times the number of beds for each facility to arrive at the fair rental value amount.
(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the calendar quarter that includes the rate effective date. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.
(5) If there are fewer than six (6) nonleased homes with rates established that are licensed as extensive support needs residences for adults, then the historical cost of property per bed used in the fair rental value calculation shall be one hundred eighteen thousand seven hundred fifty dollars ($118,750).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-20.5; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 10. 405 IAC 1-12-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-22 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate

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

Sec. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through ~~20~~ **20.5** of this rule, the procedures described in this section apply to intermediate care facilities for the mentally retarded with eight (8) or fewer beds (community residential facilities for the developmentally disabled), except for intermediate care facilities for the mentally retarded licensed as:

(1) small behavior management residences for children for which the procedures described in this section apply to facilities with six (6) or fewer beds; ~~and~~
(2) small extensive medical needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds; **and**
(3) extensive support needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds.

(b) Costs related to staffing shall be limited to the following:

Type of License	Staff Hours Per Resident Day
Sheltered living	4.5
Intensive training	6.0
Developmental training	8.0
Child rearing	8.0
Child rearing residences with specialized programs	10.0
Basic developmental	10.0
Small behavior management residences for children	12.0
Small extensive medical needs residences for adults	12.0
Extensive support needs residences for adults	**24.0**

(c) Any change in staffing that exceeds the current limitations of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children will require approval on a case-by-case basis, upon application by the facility. This approval will be determined in the following manner:

(1) A new or current provider of service ~~which~~ **that** seeks staffing above four and one-half (4.5) hours per resident day for adults or eight (8) hours per resident day for children must first obtain approval from the ~~DDARS,~~ **DDRS,** based upon the ~~DDARS~~ **DDRS** assessment of the program needs of the residents. The ~~DDARS~~ **DDRS** will establish the maximum number of staff hours per resident day for each facility, which may

be less than but may not be more than the ceiling for each type of license. If a change in type of license is required to permit the staffing limitation determined by the ~~DDARS,~~ **DDRS,** then the ~~DDARS~~ **DDRS** will make its recommendation to the licensing authority and convey to the office of Medicaid policy and planning the decision of the licensing authority. The office shall:

(A) conduct a complete and independent review of a request for increased staffing; and ~~shall~~

(B) retain final authority to determine whether a rate change will be granted as a result of a change in licensure type.

(2) If a provider of services holds a current license ~~which~~ **that** would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the ~~DDARS~~ **DDRS** may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each community residential facility for the developmentally disabled provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; filed Aug 15, 1997, 8:47 a.m.: 21 IR 81; filed Oct 31, 1997, 8:45 a.m.: 21 IR 953; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA)

SECTION 11. **Notwithstanding 405 IAC 1-12-24, the assessment methodology, for the initial rates for the extensive support needs residences for adults, determined on the implementation of this rule, and until there are six (6) or more small extensive support needs residences for adults, for which a base rate has been determined, the office or its contractor shall calculate the provider monthly assessment amount, described at 405 IAC 1-12-24, to equal the monthly assessment applicable to the provider at the fiftieth percentile rate for the small extensive medical needs residences for adults multiplied by one hundred fifty-two percent (152%), for the applicable quarter. This methodology shall be effective until there are six (6) or more small extensive support needs residences for adults, and then after that date, the office shall establish provider assessments, as described in 405 IAC 1-12-24, and this SECTION shall expire.**

SECTION 12. **Notwithstanding SECTION 1 of this document, to ensure appropriate base rates for extensive support needs residents for adults, if there are six (6) or more small extensive support needs residences for adults that receive initial state licensure and Medicaid certification on or before the effective date of this rule, then the office or its contractor shall establish the average inflated allowable cost of the median patient day, and the average historical cost of property of the median bed applicable to base rates effective on the first day of the tenth month following the effective date of this rule. The office or its contractor shall perform a desk audit of the nine (9) month historical financial reports required by 405 IAC 1-12-5(b) for all extensive support needs residences for adults that receive initial state licensure and Medicaid certification on or before the effective date of this rule. These nine (9) month historical financial reports shall be used to determine the average historical cost of property of the median bed and the average inflated allowable cost of the median patient day, pursuant to the methodology defined at SECTION 1(g) and 1(h) of this document, respectively. This methodology shall be effective on the first day of the tenth month following the effective date of this rule, and then after that date, the office shall establish provider base rates as described in SECTION 1 of this document and this SECTION shall expire.**

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