msa MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Nursing Facilities 03-08

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Subject:
- Nursing facility per diem rate determination
- Nursing Facility Quality Programs for FY 2003-2004
- Nursing Facility Class I Rate Relief

Programs Affected: Medicaid

Effective Date: October 1, 2003

This bulletin outlines the following:

- SECTION 1: Nursing Facility Per Diem Rate Determination
- SECTION 2: Nursing Facility Quality Programs for FY 2003-2004
- SECTION 3: Nursing Facility Class I Rate Relief

Changes include defining the QAAP for fiscal year 2004; modifying and clarifying the terms and process used in nursing facility reimbursement, such as a facility's variable rate base (VRB), and cost component (VCC); use of the VRB in calculating NF Class I Rate Relief; and revising the nursing facility Class I rate relief methodology. NF Class I Rate relief methodology is being revised to be consistent with changes in the rate determination process effective October 1, 2003 outlined in bulletin Nursing Facilities 02-05 and in this bulletin.

SECTION 1: NURSING FACILITY PER DIEM RATE DETERMINATION

SECTION 1.1 DEFINITIONS - FACILITY LEVEL

AVAILABLE BED

All nursing facility beds are considered available for occupancy, except in the following situations:

- Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payments for New Admissions [DPNA] action)

- Beds covered under a MDCH approved Non-available Bed Plan

- Beds temporarily unoccupied due to renovation or construction where DCIS has deemed the beds unacceptable for occupancy.

AVAILABLE BED DAYS

The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost-reporting period in which they are available.

BASE COSTS

Base costs are those costs which cover activities associated with direct resident care. Major categories under these categories are payroll and payroll related (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, activities, social services; raw and processed food; linen (does not include springs and mattresses); worker's compensation; utility costs; consultant costs for base cost categories from related organizations (with profit removed); and medical and nursing supply costs included in the base cost departments.

With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as defined above, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.

BASE COSTS PER DAY (BC/D)

A facility's base cost per day is the facility base costs divided by the total number of resident days for the same period.

BC/d=base costs/total # of resident days

BASE COST COMPONENT, INDEXED

See Indexed Base Cost Component.

CENSUS DAY

A census day is counted when a resident is occupying a nursing facility bed at days end (midnight) or a resident is on therapeutic leave at days end (midnight) and the facility is being reimbursed to hold the bed. A resident is counted for census purposes if the resident is away from the facility for therapeutic leave and the facility is being paid to hold the bed, (therapeutic leave days paid by the resident or Medicaid). A resident is not counted for census purposes if the resident is admitted to the hospital, even if the facility is being reimbursed by any payer source to hold the bed. A resident is counted for census purposes on the day of admission, but not on the day of discharge.

COST INDEX (CI)

A facility's cost index is Global Insight's Skilled Nursing Facility Market Basket without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2003 to September 30, 2004 rate year will be indexed to October 1, 2002.

CURRENT PROVIDER

A current provider is defined as the provider that operated the facility during the time period of the last cost report on which normal rate setting would occur.

ECONOMIC INFLATIONARY UPDATE (EIU)

The economic inflationary update for a facility is the Economic Inflationary Rate (EIR) for the class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.

EIU=EIR x (lesser of VRB or Class VCL)

FACILITY

For purposes of this bulletin, "facility" refers to the nursing unit being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes.

INDEXED BASE COST COMPONENT (BCC)

A facility's base cost component is the facility's total per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

BCC=(base costs/total # resident days) x CI

INDEXED SUPPORT COST COMPONENT (SCC)

A facility's support cost component is the facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.

SCC=BCC x applicable S/B ratio (facility or bed size group)

INDEXED VARIABLE COSTS (IVC)

A facility's indexed per patient day variable costs is the facility's allowable variable costs per patient day (VC/pd) indexed to October 1 of the year that is one year prior to the rate year being calculated.

IVC=VC/pd x CI

NET QUALITY ASSURANCE SUPPLEMENT (NET QAS)

The Net Quality Assurance Supplement is the Quality Assurance Supplement minus the bed fee assessment (fee per licensed bed per day)

Net QAS=QAS – bed fee

NEW FACILITY

A new facility is a provider operating a nursing facility where there are no Medicaid historical costs. Examples include:

- A newly constructed facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different provider class.
- An existing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past 2 years.

NEW PROVIDER IN A MEDICAID ENROLLED FACILITY

A new provider in a Medicaid Enrolled facility is a person or business entity that has purchased or is purchasing a nursing facility that has previously had Medicaid participation and whose ownership individual(s) or business entity are not related through family or business ties to the ownership individuals or business entity of the previous provider. Under certain circumstances, a sale between family members may be approved by the Department and the new owner may be considered a new provider.

OCCUPANCY

See Resident Days/Occupancy.

OCCUPANCY RATE (OR)

A facility's occupancy rate is the total number of resident days in a given time period divided by the number of available beds in the facility for the same time period.

OR=resident days/available beds

PROVIDER

For purposes of this bulletin, "provider" refers to a licensed nursing facility entity that has a provider agreement with Medicaid.

PER PATIENT DAY COST (X/PD)

The per patient day cost for any cost component (X) of the facility rate is the total cost for that component divided by the total number of resident days. The number of resident days used will be the greater of either the number of resident days as listed in the facility's cost report or 85% of the total number of available bed days for the cost-reporting period.

QUALITY ASSURANCE SUPPLEMENT (QAS)

The Quality Assurance Supplement for a facility is calculated by multiplying the Quality Assurance Assessment Factor (QAAF; see Definitions: Class Level) for the class by the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.

QAS=QAAF x (lesser of VRB or Class VCL)

RESIDENT DAYS/OCCUPANCY

Resident days or occupancy for a facility is the sum of the census days in a specified period of time.

For example, to calculate the resident days for a particular day, total the census days for that day. The calculation for June 30, 2003 would be as follows:

6-30-03 Residents occupying beds in facility	100
6-30-03 Residents on therapeutic leave	5
6-30-03 Residents hospitalized	3
Total Resident days for 6-30-03	105

SUPPORT COSTS

Support costs are those costs which are payroll and payroll related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs (not specifically identified as base); all equipment maintenance and repair costs; purchased services and contract labor not specified as base costs.

SUPPORT COSTS PER DAY (SC/D)

A facility's support costs per day is the facility's support costs divided by the total number of resident days for the same period.

SC/d=support cost/total # of resident days

SUPPORT COST COMPONENT , INDEXED

See Indexed Support Cost Component.

SUPPORT-TO-BASE RATIO (S/B-FACILITY)

A facility's support-to-base ratio is the allowable support costs divided by the allowable base costs. The provider's S/B ratio is limited to the 80th percentile S/B ratio for the provider's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of the type of bed. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The provider's S/B ratio is rebased annually from the most recent audited base period, regardless of ownership.

S/B Ratio=support costs/base costs

VARIABLE COSTS (VC)

A facility's variable costs are the total allowable base and support costs for a facility to provide routine nursing services to residents, as determined in accord with the Allowable Costs section of the LTC Facility Provider Manual.

VC= base costs + support costs

VARIABLE COST COMPONENT (VCC)

A facility's Variable Cost Component is the lesser of the facility's Variable Rate Base OR the Class Variable Cost Limit, plus the Economic Inflation Update.

VCC=(lesser of VRB or VCL) + EIU

VARIABLE COSTS, PER PATIENT DAY (VC/PD)

A facility's variable cost per patient day is the facility's variable costs (total allowable base and support costs) divided by the total number of resident days for the same period.

VC/pd=(base costs + support costs)/total # resident days

VARIABLE COSTS, INDEXED

See Indexed Variable Costs.

VARIABLE RATE BASE (VRB)

A facility's variable rate base is the sum of the facility's indexed base cost component and the facility's per patient day indexed support cost component. For rate setting purposes, the figure used as the provider's variable rate base will be the lesser of the provider's calculated variable rate base or the class Variable Cost Limit.

VRB=lesser of (BCC + SCC) or Class VCL

1.2 VARIABLE RATE BASE: SPECIAL SITUATIONS

HOSPITAL LTC UNITS (HLTCU)

Hospital long term care units with a Certificate of Need approval dated on or after July 1, 1990, shall be reimbursed according to the method for Class III facilities except that their variable rate base shall be determined as the lesser of their variable rate base or the Class I variable cost limit (VCL). HLTCUs with a CON approval for renovation on or after July 1, 1990 and that were in existence prior to July 1, 1990 will not be subject to this provision.

NEW FACILITIES

The Variable Rate Base for new facility will be determined using special methods, which are required because such providers have an inadequate or no Medicaid cost basis on which to determine rates.

During the first two cost-reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the class Average of Variable Costs. In subsequent periods, the facility's variable rate base will be determined using the methods described in "Variable Cost Component."

1.3 DEFINITIONS: CLASS LEVEL

CLASS AVERAGE OF VARIABLE COSTS (AVC)

The class average variable cost is defined as the total indexed variable costs for all facilities in the class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class.

AVC= (total IVC for all NF's in the class)/
(total resident days for all NF's in the class)

Example: The AVC for October 1, 2003, which is used for rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports ending in 2002 indexed to October 1, 2002.

CLASS VARIABLE COST LIMIT (VCL)

The variable cost limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC, then accumulating Medicaid resident days

of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this class of providers is reached. The Variable Cost Limit for the class of providers equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

Example: The VCL for October 1, 2003, which is used for rate year October 1, 2003 through September 30, 2004, is based on variable costs reported in cost reports ending in 2002 indexed to October 1, 2002.

ECONOMIC INFLATION RATE (EIR)

The state legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

QUALITY ASSURANCE ASSESSMENT FACTOR (QAAF)

The Quality Assurance Assessment Factor for a class of nursing facilities is the percentage increase determined and implemented by MDCH.

SUPPORT-TO-BASE RATIO-BED SIZE GROUP LIMIT (S/B-GROUP)

The support-to-base ratio limit for a bed size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank ordering providers within the same bed-size group from the lowest to the highest S/B ratio, then accumulating Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.

1.4 RATE DETERMINATION PROCESS

A nursing facility's per diem rate is made up of three components: a plant cost component, a variable cost component, and add-ons. For examples of the Medicaid rate calculation for Class I nursing facilities (Provider Type 60), see Attachment A. For examples of the Medicaid rate calculation for Class III nursing facilities (Provider Types 61 and 62), See Attachment B. See Attachment C for Timelines for Nursing Facility Per Diem Rate Setting Process.

For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.

For Class III facilities, the Plant Cost Component is the lesser of the Plant Cost Component or the Plant Cost Limit for the Class. The Plant Cost Component is the depreciation and interest expenses calculated on a per patient day basis.

For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Examples of Add-ons to a facility's per diem rate for either class include nurse aide training and testing cost reimbursement and reimbursement for special dietary costs.

Per diem rates for Class V nursing facilities, ventilator dependent care units, are set prospectively. Services included in the per diem rate are outlined by contract with the Department.

Nursing facility providers will be reimbursed either the lower of their customary charge to the general public or a prospective payment rate determined by Medicaid. For rate setting periods beginning on or after October 1, 2003, the variable cost component for facilities in Class I, Class II, and Class III will be determined as outlined below. Rate setting for prior periods will be made in accordance with the policy in effect at the beginning of the provider's rate-setting period. Payment rates described in this section refer to the provider's per resident per diem prospective payment rates, and are generally set 30 days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the Department's budget.)

Prospective payment rates will be calculated using the facility's cost report ending in the previous calendar year. If this cost report covers a time period that is less than seven months, the cost report used for rate setting will be the most current cost report available prior to the previous calendar year and which covers a period of at least seven months.

The reimbursement rate determination rebasing process will use a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate will be calculated using the filed cost report, if the cost report was acceptable and was filed with the MDCH rate setting office within five months from the end date of the cost-reporting period. If an acceptable cost report was not filed within this time frame, the MDCH rate setting office is not required to set the prospective payment rate in advance of the State's fiscal year.

1.5 Retroactive Rate Changes

A retroactive change will be made for those providers who have interim prospective rates based on filed cost reports. A retroactive change may be made:

- For facilities who were approved for Plant Cost Certification due to capital cost changes, unavailable bed plan, or plant rate affected by a DEFRA rate limitation for the cost report time period,
- For facilities that were retrospectively settled because they were granted Emergency Rate Relief,
- For audit adjustments that are required as a result of an appeal,
- For audit adjustments that are required as a result of fraud or provider failure to disclose required financial information,
- For Class I nursing facilities approved for Rate Relief for the rate year period.

SECTION 2: NURSING FACILITY QUALITY PROGRAMS FOR FY 2003-2004

2.1 QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) FOR CLASS I NURSING FACILITIES AND CLASS III NON-PUBLICLY-OWNED HOSPITAL LTC UNITS

To comply with Public Act 113 of 2003, the Department of Community Health is making changes to the Class I nursing facility reimbursement. The Act continues the Quality Assurance Assessment Program (QAAP) and directs the Department to incorporate funds resulting from collection of the quality assurance assessment fee into the Medicaid reimbursement to nursing facilities.

Effective for fiscal year 2003-2004, Class I nursing facilities will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on the facility's annual historical Medicaid utilization multiplied by the facility's Quality Assurance Supplement (QAS) on a per resident day basis for FY 2003-2004, divided by 12. A facility's Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility plus all routine nursing care and therapeutic leave days where Medicaid paid room and board for hospice residents.

A facility's QAS is equal to the lesser of the facility's variable rate base or variable cost limit times the Quality Assurance Assessment Factor (QAAF) determined by the Department. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed, audited cost report data, and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment fee and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the QAAF may not exceed 6% of total industry revenue for the fiscal year. The estimated QAAF for FY 2003-04 is 23.6% for Class I and non-publicly owned Class III nursing facilities.

See Attachment A, pages 2-5 for an example of the QAS calculation for Class I nursing facilities. See Attachment B, page 4 for an example of the QAS calculation for non-publicly owned Class III nursing facilities.

2.2 QUALITY ASSURANCE ADJUSTMENT FOR PUBLICLY-OWNED CLASS III NURSING FACILITIES (COUNTY MEDICAL CARE FACILITIES AND PUBLICLY-OWNED HOSPITAL LTC UNITS)

The Quality Assurance Adjustment for publicly owned Class III nursing facilities in fiscal year 2003-2004 will be a continuation of the 3% increase outlined in Medical Services Administration bulletin Nursing Facilities 03-05 issued June 1, 2003. Effective for fiscal year 2003-2004, Class III nursing facilities will receive a quality payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on the facility's annual historical Medicaid utilization multiplied by the facility's Quality Assurance Supplement (QAS) on a per resident day basis for FY 2003-2004, divided by 12. A facility's Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility plus all routine nursing care and therapeutic leave days where Medicaid paid room and board for hospice residents.

The QAS is equal to the lesser of the facility's variable rate base or variable cost limit times a Quality Assurance Assessment Factor (QAAF) of 3%. A provider's QAS will be reconciled at the end of the fiscal year based on the actual Medicaid utilization and to reflect changes to the facility's Variable Rate Base from filed, audited cost report data.

See Attachment B, page 2 for an example of the QAS calculation for publicly owned Class III nursing facilities.

2.3 Quality Assurance Assessment Program (QAAP) for Class V Nursing Facilities (Ventilator dependent care Units)

Effective for fiscal year 2003-2004, Class V ventilator dependent care units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on the unit's annual historical Medicaid utilization multiplied by the unit's Quality Assurance Supplement (QAS) on a per resident day basis for FY 2003-2004, divided by 12. A unit's Medicaid utilization will include all days billed to Medicaid by the unit. The QAS is equal to the Class I average variable cost multiplied by the Quality Assurance Assessment Factor (QAAF) determined by the Department.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment fee and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the QAAF may not exceed 6% of total industry revenue for the fiscal year. The estimated QAAF for FY 2003-04 is 23.6% for Class V units.

A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

Section 3: Nursing Facility Class I Rate Relief

3.1 Criteria for Eligibility for NF Class I Rate Relief

Eligibility for NF Class I Rate Relief for new and current nursing facility providers will be determined on a case-by-case basis according to the following criteria:

- The provider must be a Class I nursing facility provider, AND
- The provider must demonstrate that the current Medicaid rate does not provide adequate funding to deliver the level of care to the Medicaid beneficiaries in the facility such that "each resident attains and maintains the highest practicable physical, mental, and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987, AND
- The nursing facility Variable Rate Base amount meets the following criteria:
  - For a Current Provider -The facility's Variable Rate Base is at or below the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is

the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested, OR

- For a New Provider in a Medicaid-enrolled nursing facility –The facility's current Variable Rate Base is at or less than 80 percent of the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. (A new facility with a Variable Rate Base between 80 and 100% of the corresponding class Average Variable Cost will be eligible for accelerated rebasing and will be treated as a current provider); AND

- A current Medicaid provider agreement for the facility is in effect. The rate relief period will be based on the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period would not end the agreement for rate relief under this policy, so long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement; AND

- The provider must also meet at least one of the following five criteria:

  - The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per patient day for the two years prior to the first year of rate relief. Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs. To demonstrate this difference, the provider must submit the per diem cost analysis using the form in Attachment D, OR

  - The provider is required, as a result of a survey by the state or federal regulatory agency, to correct one or more substandard quality of care deficiency to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s), OR

  - The facility has a significant change in the level of care needed for current Medicaid residents. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. The Minimum Data Set (MDS) data must be used for this comparison. This data will be subject to a clinical review by MDCH clinical staff. The analysis must also include a comparison of the previous and current nursing staffing levels required and other nursing related costs or requirements likely to increase the operational costs; OR

  - The provider is new in a Medicaid Enrolled facility and the facility's most recent cost report submitted to MDCH was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting would include non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors in accord with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate, OR

- Rate relief is needed because the facility will be closed due to a regulatory action by the state or federal regulatory agency where the facility's closure will result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider will operate the facility at its current reimbursement rate. A facility would meet this hardship criteria if it is the only nursing facility in the county, or the closing facility has at least sixty-five percent of the Medicaid certified beds in that county.

3.2 RATE RELIEF PETITION PROCESS

All petitions for NF Class I Rate Relief must be in writing and submitted to the MDCH rate- setting office. A corporate officer from the entity that holds the nursing facility license must sign the rate relief petition.

The MDCH rate-setting office will make the final determination for approval or disapproval regarding the rate relief request. A rate relief request will receive a written response within 60 days of the request. The response can be either a decision regarding approval or disapproval of the request or a request for additional information. Once the provider has complied with requests for additional information, a determination of approval or disapproval of the request will be given within 30 days of receipt of the additional information.

3.3 RATE RELIEF AGREEMENT

If NF Class I Rate Relief is approved, the MDCH rate setting office will prepare a rate relief agreement to be signed by the provider and the MDCH rate setting office. Once the agreement is approved, the provider's Medicaid rate will be adjusted in accord with the relief granted. The agreement will outline the rate relief and requirements.

Requirements may include but are not limited to:

- Annual and interim cost-reporting requirements during the period of rate relief.
- Appointment of a monitor, at facility cost, for oversight if determined needed in consultation with the state regulatory agency.
- Follow-up surveys by the state regulatory agency.

3.4 NF CLASS I RATE RELIEF PERIOD

Rate relief will be effective on a prospective basis only after receipt of the request by MDCH. No retroactive rate relief will be approved.

Providers may apply and receive rate relief under this policy once every 7 years (84 months). This seven-year period begins on the effective date of rate relief. If rate relief takes effect January 1, 2003, the provider would not be eligible for rate relief until on or after January 1, 2010. The rate relief period will be based on the facility, and not the owner or licensee. A change of ownership would not void the seven-year period under this policy.

3.5 WITHDRAWAL OF RATE RELIEF AGREEMENT

The NF Class I Rate Relief agreement may be withdrawn by MDCH if the facility is cited by the state or federal regulatory agency for serious certification violations while receiving rate relief. Such citations would be for serious and immediate threat or substandard quality of care. In this situation, the existing agreement will be reviewed by MDCH. If the agreement is terminated by MDCH, the Medicaid rate will be recalculated in accordance with existing Medicaid reimbursement policy. The rate change would take effect at the beginning of the month following issuance of a 30-day notice to the provider.

3.6 RATE RELIEF APPEALS

Providers who received notices of denial for NF Class I Rate Relief or who are notified that a rate relief agreement has been withdrawn may file an appeal. Appeals will be handled in accordance with the existing appeals process, and should be filed with:

Appeals Section
Administrative Tribunal and Appeals Division
Policy and Legal Affairs Administration
Department of Community Health
P. O. Box 30195
Lansing, Michigan 48909
Phone 517-335-5231

3.7 NF CLASS I RATE RELIEF FOR A NEW PROVIDER IN A MEDICAID ENROLLED NURSING FACILITY WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 80% OF THE CLASS AVERAGE VARIABLE COST

New providers that meet the criteria outlined above may request an increase in the current facility rate. A new provider is defined as one whose ownership individual(s) or business entity is not related through family or business ties to the ownership individuals or business entity of the previous provider. The new provider must be operating in a facility that has previously participated with Medicaid.

3.7.A NF CLASS I RATE RELIEF METHODOLOGY FOR A NEW PROVIDER IN A MEDICAID ENROLLED FACILITY WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 80% OF THE CLASS AVERAGE VARIABLE COST

New providers who meet the criteria above and that have a Variable Rate Base less than or equal to 80% of the Class I Average Variable Cost may apply for NF Class I Rate Relief. A new rate will be calculated using the Class I average variable cost for the appropriate year as the variable rate base for the calculation of the facility variable cost component, thereby increasing the facility per diem rate. This variable rate base will be in effect through the current State fiscal year rate period ending September 30.

Effective October 1 of the State fiscal year rate period starting after the new provider begins operation, the variable rate base will be determined under accelerated rebasing. The accelerated rebasing will utilize the new provider's first cost-reporting period that reflects at least seven months of nursing facility operations. The cost-reporting time period will be based upon the new provider's established fiscal year. The nursing facility allowable variable cost will be indexed to October 1 of the year that is one year prior to the new rate year being calculated, by applying the appropriate Cost Index. The new provider variable rate base will be limited to the Class I average variable cost for the corresponding rate year time period.

The new provider receiving rate relief in this category must file a Class I Rate Relief Interim Cost Statement prior to September 15. The Interim Cost Statement must reflect actual or expected costs incurred by the nursing facility for the new provider's first cost-reporting period (as referenced above). The facility's annual cost report may be used in lieu of the Interim Cost Statement if the cost report will be filed with MDCH prior to September 15.

The Rate Relief Interim Cost Statement must contain these completed schedules of the cost report:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The interim Cost Statement will be used to determine the interim rate utilizing the accelerated rebasing provisions. The interim rate will be revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

The subsequent rate year calculation will be in accordance with standard reimbursement methodology.

Example: A new provider that began operations on January 1, 2004, selects a September 30 year-end cost report period, requests and is approved for NF Class I Rate Relief for rate year October 1, 2003 to September 30, 2004. The facility per diem rate will be set using the Class I average variable costs (AVC) effective for the rate year beginning October 1, 2003 (applicable to this new Provider January 1, 2004). The provider must complete an interim cost statement for actual and expected variable costs for the period January 1, 2004 through September 30, 2004, which must be filed by September 15, 2004. Effective October 1, 2004 the variable rate base will be the lesser of the variable costs from the interim cost statement, indexed to October 1, 2003 OR the Class I Average Variable Cost effective October 1, 2004. Following the filing of the annual cost report, the variable costs from the annual report will be indexed to October 1, 2003 and the interim variable rate base recalculated.

Rate relief will be subject to audit and settlement reimbursement adjustment using the principles and guidelines outlined in Medicaid policy and shall not exceed the appropriate cost and rate limitations. The provider will be reimbursed by MDCH for an underpayment, and the provider must reimburse MDCH for overpayment. If the interim variable rate base rate relief reimbursement to the provider exceeds audited variable rate base reimbursement by greater than 3%, there will be a penalty to the provider equal to 10% of the total variable overpayment amount.

The provider would also be allowed to participate in any other add-on reimbursement programs at their election. These programs will be handled under the Medicaid policy applicable to the program. The costs associated with these add-on programs will not be included in the cost settlement of the variable costs for rate relief as previously described.

3.7.B RATE RELIEF DOCUMENTATION FOR A NEW PROVIDER IN A MEDICAID ENROLLED FACILITY WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 80% OF THE CLASS AVERAGE VARIABLE COST

It is the provider's responsibility to present the supporting documentation. Rate relief petitions from new providers must include:

- The applicable criteria for the situation.
- Supporting documentation for the criteria.
- Detail regarding the circumstances causing the need for the rate relief request.
- The period for which rate relief is requested.
- The proposed effective date. The actual effective date of the rate relief will be based on the date that the petition is received by the Department. The earliest effective date would be the first day of the next month. For example, a petition received on August 31 may be effective as soon as September 1.
- Specific cost details on how the additional funds will be spent (i.e. staffing, consultants, medical supplies, etc.).
- Plans on how these changes will ensure the required level of resident care.

3.8 NF CLASS I RATE RELIEF FOR A CURRENT PROVIDER AND A NEW PROVIDER IN MEDICAID ENROLLED NURSING FACILITIES WITH A VARIABLE RATE BASE BETWEEN 80-100% OF THE CLASS AVERAGE VARIABLE COST

Providers who meet the criteria outlined above may request accelerated rebasing. A current provider is defined as the provider that operated the facility during the previous cost-reporting period and who will operate the facility during the period for which rate relief is being requested. For purposes of rate relief, a new provider is defined as one whose ownership individual(s) or business entity is not related through family or business ties to the ownership individuals or business entity of the previous provider. This does not include a Department approved sale between family members. The new provider must be operating in a facility that has previously participated in the Medicaid program

Only current Class I nursing facilities are eligible for Rate Relief and it applies only to the facility's Variable Rate Base. The provider's qualification for Plant Cost Component of the Medicaid rate and Nurse Aide Training and Testing costs will be handled in accordance with current Medicaid policy.

3.8.A NF CLASS I RATE RELIEF METHODOLOGY FOR CURRENT PROVIDERS AND NEW PROVIDERS IN EXISTING FACILITIES WITH A VARIABLE RATE BASE BETWEEN 80-100% OF THE CLASS AVERAGE VARIABLE COST

Accelerated rebasing is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility allowable variable cost will be indexed to October 1 of the year that is one year prior to the rate year being calculated, by applying the appropriate Cost Index.

Example: Provider cost report for the period ending December 31, 2003, could be used to set the October 1, 2003 rate if approved for rate relief under this policy. The provider would be allowed to participate in any add-on reimbursement programs at their election.

The cost-reporting will be based upon the provider's established fiscal year, and must not cover a time period of less than 7 months. The cost report period used for accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year.

Example: A cost report time period ending after January 1, 2004 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2003 through September 30, 2004.

3.8.B RATE RELIEF DOCUMENTATION FOR CURRENT PROVIDERS AND NEW PROVIDERS IN EXISTING FACILITIES WITH A VARIABLE RATE BASE BETWEEN 80-100% OF THE CLASS AVERAGE VARIABLE COST

It is the provider's responsibility to present the supporting documentation. Rate relief petitions from current providers must include the following documentation:

- The applicable criteria for the situation.
- Supporting documentation for the criteria.
- Detail regarding the circumstances causing the need for the rate relief request.
- The period for which rate relief is requested.
- The proposed effective date. The actual effective date of the rate relief will be based on the date that the petition is received by the Department. The earliest effective date would be the first day of the next month. For example, a petition received on August 31 may be effective as soon as September 1.
- Detail regarding the expenses that are not in the base period for the current or next fiscal year Medicaid rate and how these expenditures relate to the provision of resident care.
- Plans on how these changes will ensure the required level of resident care.

SECTION 4 RESOURCES AND MANUAL MAINTENANCE

4.1 QUESTIONS

The DCH Rate-Setting Office [Data Analysis, Reimbursement and Settlement Division (DARS)] may be reached at 517-355-5356 or DARS@michigan.gov.

Further information about cost reporting may be found on-line at www.michigan.gov/ltc, click on "Providers and Professionals", LTC Provider Forms

4.2 MANUAL MAINTENANCE

The following bulletins may be discarded:

Long Term Care 95-02, Special Rate Relief for Class I Long Term Care Providers, issued May 1, 1995.
Long Term Care Facilities 00-03, Special Rate Relief, issued July 1, 2000

The following bulletins are superseded. Retain them until your cost settlement is completed for the relevant years.

Nursing Facilities 02-05, Quality Assurance Adjustment
Nursing Facilities 03-05, Quality Assurance Adjustment for Publicly-Owned Class III Nursing Facilities

Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class I-Provider Type 60

III. Property Tax/Interest Expense/Lease Component

Filed Period End: 6/30/02

	Total Days:	17,761
	Plant Costs:	58,431

A.	**Allowable borrowings limitation**	
	1) Average borrowings balance	496,600
	2) Interest deduction for excess borrowings	0
	3) DEFRA sales disallowance	0
	4) Net property tax/ interest/ lease component	58,431
B.	**Per patient day plant component**	**3.289849**

IV. Return On Current Asset Value Component

Tenure: 20

A.	Updated Building and Land Improvements	1,736,925
B.	Depreciated Moveable Equipment	95,691
C.	Land	51,996
D.	Total current asset value	1,884,612
E.	Percenta ge applicable to LTC unit	100.00%
F.	LTC unit current asset value x percent	1,884,612
G.	Current Asset Value upper (ceiling) limitation	2,193,000
H.	urrent Asset Value lower (floor) limitation	657,900
I.	Tenure factor	0.0525
J.	Limitation or asset value x tenure factor	98,942
K.	**Limitation or asset value x tenure factor/patient days**	**5.570753**

Rate Calculation

Prospective Reimbursement

A.	Lesser of Variable Rate Base of Variable Cost Limit	115.798670
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A Plus Line B)	115.798670
D.	Plant Cost Component	8.860602
E.	Reimbursement Rate Prior to Add-Ons	**124.659271**

OBRA Training & Testing Cost Settled

Period End: 6/30/02	W/S 8 Costs:	**Filed**	5,644	**0.317775**

Special Dietary

Medicaid Reimbursement Rate **124.977046**

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #1
Provider Number:	60-1111111
F.Y.E:	December 31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

Total Beds:	120
Medicaid-certified LTC Beds:	100

A.	Variable cost per day	Filed Period End: 12/31/02		102.632807
B.	Base cost per day			76.092223
C.	Support cost per day			26.540584
D.	Provider's support/base ratio			0.348795
E.	Support/Base ratio limit per bed size group			0.340100
F.	Cost Index (CI)	From: 12/31/2002	To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)			75.540859
H.	Indexed support cost component (SCC) (lesser of Provider's S/B ratio or S/B limit times indexed base cost)			25.691446
I.	Variable Rate Base (VRB) (base cost component plus support cost component)			101.232305
J.	Variable Cost Limit (VCL)	As of: 10/01/2003		123.750000
K.	Lesser of Variable Rate Base or Variable Cost Limit			101.232305

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		101.232305
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not part of rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	101.232305
B.	Quality Assurance Assessment Factor (QAAF)	23.6%
C.	Quality Assurance Supplement	23.890824

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #2
Provider Number:	60-2222222
F.Y.E:	September 30
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

	Total Beds:	92
	Medicaid-certified LTC Beds:	81
A. Variable cost per day	Filed Period End: 9/30/02	116.540413
B. Base cost per day		91.907033
C. Support cost per day		24.633380
D. Provider's support/base ratio		0.268025
E. Support/Base ratio limit per bed size group		0.341900
F. Cost Index (CI)	From: 09/30/2002 To: 10/01/2002	1.000000
G. Indexed base cost component (BCC) (base cost per day times CI)		91.907033
H. Indexed support cost component (SCC) (lesser of Provider's S/B ratio or S/B limit times updated base cost)		24.633380
I. Variable Rate Base (VRB) (base cost component plus support cost component)		116.540413
J. Variable Cost Limit (VCL)	As of: 10/01/2003	123.750000
K. Lesser of Variable Rate Base or Variable Cost Limit		116.540413

II. Economic Inflationary Update (EIU)

A. Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B. Lesser of Provider's Variable Rate Base or Variable Cost Limit		116.540413
C. Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A. Lesser of Provider's Variable Rate Base or Variable Cost Limit	116.540413
B. Quality Assurance Assessment Factor (QAAF)	23.6%
C. Quality Assurance Supplement	27.503537

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #3
Provider Number:	60-3333333
F.Y.E:	June 30
Effective Date:	10/01/2003

I. Calculation of Variable Rate Base (VRB)

		Total Beds:	92
		Medicaid-certified LTC Beds:	92
A.	Variable cost per day	Filed Period End: 6/30/02	115.666854
B.	Base cost per day		83.356269
C.	Support cost per day		32.310584
D.	Provider's support/base ratio		0.387620
E.	Support/Base ratio limit per bed size group		0.341900
F.	Cost Index (CI)	From: 06/30/2002 To: 10/01/2002	1.007353
G.	Indexed base cost component (BCC) (base cost per day times CI)		83.969188
H.	Indexed support cost component (SCC) (lesser of Provider's S/B ratio or S/B limit times updated base cost)		28.709065
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		112.678254
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	123.750000
K.	Lesser of Variable Rate Base or Variable Cost Limit		112.678254

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		112.678254
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	112.678254
B.	Quality Assurance Assessment Factor (QAAF)	23.6%
C.	Quality Assurance Supplement (QAS)	26.592068

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #4
Provider Number:	60-4444444
F.Y.E:	March 31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	62
		Medicaid-certified LTC Beds:	62
A.	Variable cost per day	Filed Period End: 3/31/02	114.192664
B.	Base cost per day		94.780375
C.	Support cost per day		19.412289
D.	Provider's support/base ratio		0.204813
E.	Support/Base ratio limit per bed size group		0.341900
F.	Cost Index (CI)	From: 03/31/2002 To: 10/01/2002	1.014064
G.	Indexed base cost component (BCC) (base cost per day times CI)		96.113366
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		19.685303
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		115.798670
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	123.750000
K.	Lesser of Variable Rate Base or Variable Cost Limit		115.798670

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		115.798670
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	115.798670
B.	Quality Assurance Assessment Factor (QAAF)	23.6%
C.	Quality Assurance Supplement (QAS)	27.328486

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class III-Publicly Owned-Provider Type 61

III. Calculation of Plant Cost Component

Filed Period End: 12/31/02

A.	Depreciation and Interest Expenses	359,738
B.	Total Days	73,098
C.	Plant Costs per Day	4.921311
D.	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	4.921311

Rate Calculation
Prospective Reimbursement

A.	esser of Variable Rate Base or Variable Cost Limit	144.028046
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	144.028046
D.	Plant Cost Component	4.921311
E.	Reimbursement Prior to Add-Ons	148.949357

OBRA Training and Testing Cost Settlement

Period End:	12/31/01	W/S 8 Costs: Filed	24,026	.328682

Medicaid Reimbursement Rate 149.278039

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class III-Publicly Owned-Provider Type 61

Date:	9/1/03
Provider Name:	Sample Medical Care Facility
Provider Number:	61-6666666
F.Y.E:	December31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

Total Beds:	204
Medicaid-certified LTC Beds:	204

A.	Variable cost per day	Filed Period End: 12/31/02	145.079291
B.	Base cost per day		114.513735
C.	Support cost per day		30.565556
D.	Provider's support/base ratio		0.266916
E.	Support/Base ratio limit per bed size group		0.329600
F.	Cost Index (CI)	From: 12/31/2002 To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)		113.683968
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		30.344078
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		144.028046
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**144.028046**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		144.028046
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

IV. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	144.028046
B.	Quality Assurance Assessment Factor (QAAF)	3.0%
C.	Quality Assurance Supplement (QAS)	4.320841

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class III-Non-Publicly Owned-Provider Type 62

III. Calculation of Plant Cost Component

		Filed Period End: 6/30/02
A.	Depreciation and Interest Expenses	215,521
B.	Total Days	14,030
C.	Plant Costs per Day	5.361440
D	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	5.410000

Rate Calculation

Prospective Reimbursement

A.	Lesser of Variable Rate Base or Variable Cost Limit	169.280000
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	169.280000
D.	Plant Cost Component	5.410000
E.	Reimbursement Prior to Add-Ons	174.690000

OBRA Training and Testing Cost Settlement

Period End:	6/30/02	W/S 8 Costs: Filed	12,00	.800000

Medicaid Reimbursement Rate 175.490000

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate
Class III-Non-Publicly Owned-Provider Type 62

Date:	9/1/03
Provider Name:	Sample Hospital LTC Unit
Provider Number:	62-7777777
F.Y.E:	June 30
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	48
		Medicaid-certified LTC Beds:	40
A.	Variable cost per day	Filed Period End: 6/30/02	201.403421
B.	Base cost per day		152.625018
C.	Support cost per day		57.778403
D.	Provider's support/base ratio		0.378564
E.	Support/Base ratio limit per bed size group		0.378600
F.	Cost Index (CI)	From: 6/30/2002 To: 10/01/2002	1.007353
G.	Indexed base cost component (BCC) (base cost per day times CI)		153.747270
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		58.203248
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		211.950518
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**169.280000**

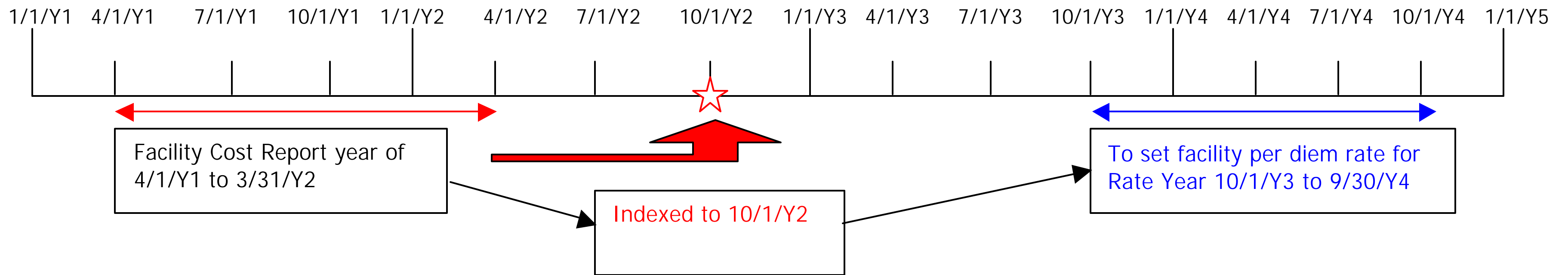
II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		169.280000
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

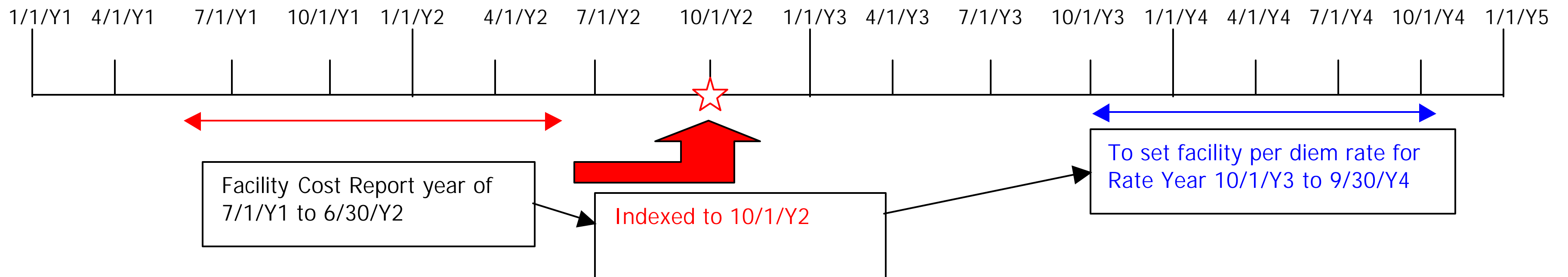
V. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	169.280000
B.	Quality Assurance Assessment Factor (QAAF)	23.6%
C.	Quality Assurance Supplement (QAS)	39.950080

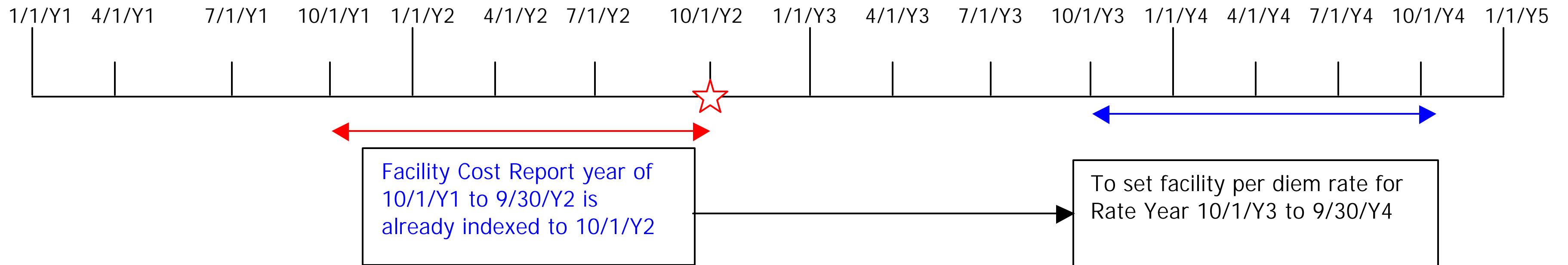
Timeline for Per Diem Rate Setting Process for Nursing Facilities with Cost Reporting Year from April 1 through March 31



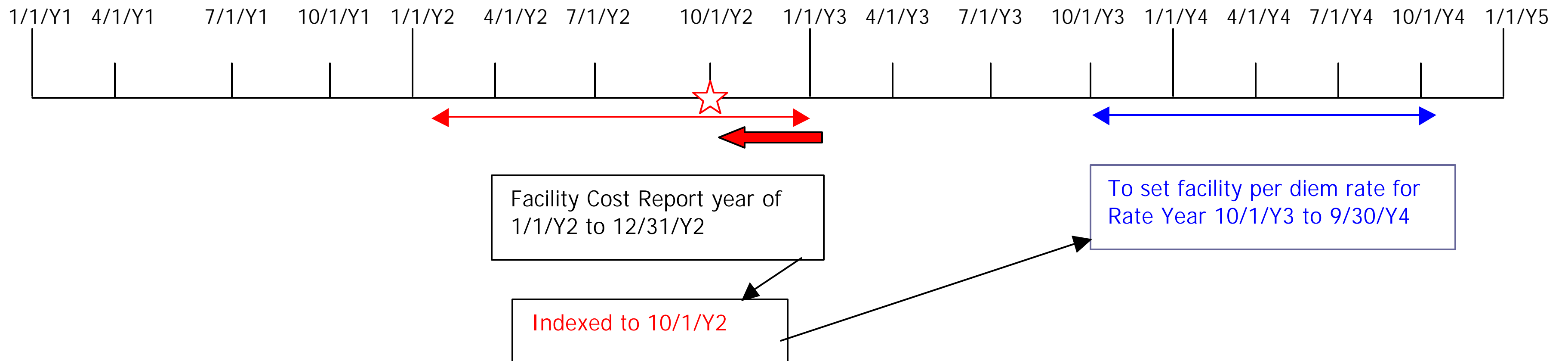
Timeline for Per Diem Rate Setting Process for Nursing Facilities with Cost Reporting Year from July 1 through June 30



Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Year October 1 through September 30



Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Years from January 1 though December 31



Form to Establish Criteria for Nursing Facility Class I Rate Relief

Criteria 5.a. The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per patient day for the two years prior to the first year of rate relief. Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs.

			Costs of 1st year prior to rate relief	Costs of 2nd year prior to rate relief
A. Variable Costs Incurred (From Worksheet 2-H Costs of Provider Cost Report)			$	$
			Costs of 1st year prior to rate relief	Costs of 2nd year prior to rate relief
B. Variable Cost Reimbursement				
Variable Rate Base			$	$
Economic Inflationary Update			$	$
Net QAS			$	$
Other Add-ons (i.e. wage pass through)			$	$
B. Total			$	$
Variable Costs Incurred in Excess of Variable Cost Reimbursement (A-B)			$	$