

**RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF TENNCARE**

**CHAPTER 1200-13-6
NURSING FACILITY LEVEL I PROGRAM**

TABLE OF CONTENTS

1200-13-6-.01	Determination of Reimbursable Costs of Level I Nursing Facility Care Provided by the Bureau of TennCare	1200-13-6-10	Medicaid Nursing Facility Level I Accounting Principles
1200-13-6-.02	Approval of the Department Required for Participation	1200-13-6-.11	Nursing Facility Level I Allowable Compensation Ranges
1200-13-6-.03	Extent of Reimbursement to be Determined by the Department	1200-13-6-.12	Allowable Compensation Ranges or Owners and/or Their Relatives Employed by Parent Companies Whose Subsidiary or Division Participates in the Bureau of TennCare Nursing Facility Level I Program
1200-13-6-.04	Billing Procedure to be Determined by the Department		
1200-13-6-.05	Charges to Level I Nursing Facility Recipients	1200-13-6-.13	Establishment of Per Diem Reimbursement Rates
1200-13-6-.06	Covered Services	1200-13-6-.14	Maximum Amount of Reimbursable Cost Payable to a Provider
1200-13-6-.07	Submission of Cost Reports by Providers		
1200-13-6-.08	Cost Report for the Nursing Facility Level I Program	1200-13-6-.15	Auditing of Cost Reports
		1200-13-6-.16	Records Retention
1200-13-6-.09	Footnotes and Instructions for the Nursing Facility Level I PCost Report		

1200-13-6-.01 DETERMINATION OF REIMBURSABLE COSTS ON LEVEL I NURSING FACILITY CARE PROVIDED BY THE BUREAU OF TENNCARE. The Department, in consultation with the Comptroller of the Treasury and the Tennessee Health Care Association, shall establish the rules and regulations for the determination of the reimbursable per diem cost for services provided to Medicaid recipients as part of the nursing facility Level I program. The method of cost determination shall include depreciation on buildings, equipment, and fixtures, and interest expense as allowable items of cost. The reimbursable per diem cost may take into consideration the kinds, levels, and quantities of services provided to the recipients by the institution, the cost of providing such services, and the levels and types of patient care required for recipients.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6-.02 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those institutions designated by and contracting with the Department as rendering Level I nursing facility services may participate and be reimbursed as a provider under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6-.03 EXTENT OF REIMBURSEMENT TO BE DETERMINED BY THE DEPARTMENT. The reimbursable costs of institutions rendering Level I nursing facility services shall be reimbursable by each recipient and the State to the extent determined by the Department with the remainder not allowable as outside support from any other source available to the provider. The provider shall be limited to reimbursable per diem rate as determined by the Comptroller as the maximum it may collect from both sources for program services.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6.04 BILLING PROCEDURE TO BE DETERMINED BY THE DEPARTMENT. Institutions providing Level I nursing facility services for Medicaid recipients shall bill the Department on the forms and in the manner designated by the Department.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. *Administrative History:* Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6.05 CHARGES TO NURSING FACILITY LEVEL I RECIPIENTS. The charge schedule of a provider must be applied uniformly to each recipient as services are furnished to the recipient. Appropriate write-offs or adjustments shall be made to each account to reduce the gross charges to the contractual or legal collection limits of the various medical programs. The Comptroller of the Treasury must be notified of any changes in the schedule of charges.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. *Administrative History:* Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6.06 COVERED SERVICES. The specific items and services covered under the Level I nursing facility program shall be those defined and approved by the Department. Other non-covered services may be charged directly to the recipient (refer to the applicable Provider Manual).

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202. *Administrative History:* Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6.07 SUBMISSION OF COST REPORTS BY PROVIDERS. Medicaid program providers of Level I nursing facility services will be required to submit to the Comptroller of the Treasury a pro-forma (budgeted) cost report upon beginning participation as a new provider. New providers shall file a first actual cost report within six (6) or nine (9) months of commencing operations, depending on proximity of starting date to fiscal year end. Leases and changes of ownership are not considered new providers for this purpose and thus no budgeted cost reports are filed for leases or changes in ownership. Thereafter, cost reports shall be filed at their fiscal year end and submitted on forms described in rule 1200-13-6.08. The report shall be due within three (3) months after the end of the designated fiscal period. An extension may be requested for due cause. Such cost reports must be completed in accordance with Medicare reimbursement principles except where these rules may specify otherwise. In the event that the provider does not file the required cost report by the due date, the provider shall be subject to a penalty of ten dollars (\$10.00) per day in accordance with state law. In the event that a provider discovers a significant omission of costs, it may file an amended cost report at any time prior to the due date of its next annual cost report. After that time, the cost report cannot be amended for cost omissions. Amended cost reports shall be subject to the same requirements as other cost reports, and will be the only accepted means to claim omitted costs. Rate increases resulting from submission of omitted costs will not be retroactive.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23. *Administrative History:* Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 25, 2002; effective October 8, 2002.

1200-13-6.08 COST REPORT FOR THE NURSING FACILITY LEVEL I PROGRAM

STATE OF TENNESSEE
 COMPTROLLER OF THE TREASURY
 DEPARTMENT OF AUDIT
 DIVISION OF STATE AUDIT
 SUITE 1500 JAMES K. POLK STATE OFFICE BUILDING
 NASHVILLE, TENNESSEE 37243-0264

IMPORTANT: Read Footnotes and Instructions and Accounting Principles before completing this form. Any form not properly completed may be rejected. DO NOT CHANGE THE EXISTING NOMENCLATURE. If the provider has accounts or descriptions that do not fit the existing categories, report the amounts in "Other" and attach a schedule with the desired nomenclature. This will keep information comparable among cost reports.

Provider Numbers:¹ Level I _____ Date Submitted _____, 19____
 Level II _____

Name of Facility ² _____

Mailing Address _____
 Street, P.O. Box, RFD City State Zip Code

Physical Address _____
 Street, P.O. Box, RFD City State Zip Code

Name of Present Administrator _____ () _____
 Telephone Number

Name of Home Office/Management
 Company _____

Mailing Address _____
 Street, P.O. Box, RFD City State Zip Code

Contact Person _____ () _____
 Telephone Number

Accounting Period Covered by this Report: From _____, 19____ thru _____, 19____
 Fiscal Year End _____

ACCRUAL ACCOUNTING MUST BE USED FOR THIS REPORT ^{3,4}
 ENTER ALL AMOUNTS IN WHOLE DOLLARS

A. Type of Facility (Check only one)

1. For Profit:	_____	Sole Proprietor	_____	Partnership	_____	Corporation
2. Nonprofit:	_____	Church	_____	Corporation	_____	Other
3. Government:	_____	State	_____	County	_____	Other

(Rule 1200-13-6-.08, continued)

B. Statistical and Other Data ⁵	(a)	(b)	(c)	(d)	(e)
Skilled	Certified Beds	(a + b) Other NF Beds	TOTAL NF BEDS	(c + d) Non-NF Beds	TOTAL BEDS
1. Licensed beds - beginning of the accounting period	_____	_____	_____	_____	_____
a. Bed change - date _____	_____	_____	_____	_____	_____
b. Bed change - date _____	_____	_____	_____	_____	_____
2. Licensed beds - end of the accounting period	_____	_____	_____	_____	_____
3. Possible bed days for the period ⁶	_____	_____	_____	_____	_____
4. Inpatient days for the period ⁷					
a. Medicare - Skilled	_____	g. Private ICF/MR		_____	
b. Medicaid - NF2	_____	h. Other NF1		_____	
c. Medicaid - NF1	_____	i. Other NF2		_____	
d. Private - NF1	_____	j. TOTAL NURSING FACILITY DAYS		_____	
e. Private - NF2	_____	(Add items a - i)		_____	
f. Medicaid ICF/MR	_____	k. Non-nursing facility days		_____	
		l. TOTAL DAYS - Add items		_____	
		j and k		_____	
5. Percent Occupancy (4.j. divided by 3.c.)					
6. Meals served during the period ⁸					
a. Patients			_____		
b. Employees			_____		
(1) Considered part of compensation (Provided free of charge)		_____			
(2) Paid for by employees		_____			
c. Guests			_____		
(1) Provided free of charge		_____			
(2) Paid for by guests		_____			
d. Owners			_____		
(1) Provided free of charge		_____			
(2) Paid for by owners		_____			
e. Total Meals			=====		

B. *Statistical and Other Data (continued)*

7. List names of all persons living in the home that are not patients and their position or relationship to the home, such as owners, employees, etc. (If none, so state).

(Rule 1200-13-6-.08, continued)

Name / Title, Position, or Relationship / Amount of Salary / Where in Section F is salary shown?

_____	_____	_____	_____
_____	_____	_____	_____

8. List changes in ownership during this reporting period and those changes anticipated during the next reporting period.

From	Type of Control	To	Type of Control	Date of Change
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

C. Balance Sheet (Date _____, 19__)

1. Assets

a. Current Assets:

(1) Cash on hand and in bank		\$_____
(2) Accounts receivable	\$_____	
Less allowance	_____	_____
(3) Other accounts receivable	_____	
Less allowance	_____	_____
(4) Notes receivable		_____
(5) Due from officers/owners		_____
(6) Inventory of supplies on hand		_____
(7) Prepaid expenses		_____
(8) Investments		_____
(9) Intercompany receivables		_____
(10) Other current assets (Specify)		
_____		_____
_____		_____

C. *Balance Sheet (continued)*

(11) Total Current Asset - Add items (1) through (10) \$_____

b. Fixed Assets:

	<u>Cost</u>	<u>Accumulated Depreciation</u>	<u>Book Value</u>
(1) Land	\$_____	_____	\$_____

(Rule 1200-13-6-.08, continued)

(2) Land Improvements	\$_____	_____	\$_____
(3) Buildings	_____	_____	_____
(4) Leasehold or building improvements	_____	_____	_____
(5) Fixed Equipment	_____	_____	_____
(6) Movable Equipment	_____	_____	_____
(7) Motor vehicles	_____	_____	_____
(8) Construction in progress	_____	_____	_____
(9) Other depreciable assets (Specify)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(10) Total Fixed Assets			
Add items (1) through (9)	\$_____	\$_____	\$_____

c. Other Assets (if any):

(1) Deposits on loan	\$_____
(2) Long term investments	_____
(3) Special funds	_____
(4) Patient trust funds	_____
(5) Unamortized pre-opening expenses	_____
(6) Unamortized organization expenses	_____
(7) Other (Specify)	
_____	_____
_____	_____
_____	_____

C. Balance Sheet (continued)

(8) Total Other Assets - Add items (1) through (7) \$_____

d. Total Assets - Add items a(11), b(9), and c(8) \$_____

2. Liabilities

a. Current Liabilities:

(1) Accounts payable \$_____

(Rule 1200-13-6-.08, continued)

- (2) Mortgages payable within one year _____
- (3) Notes and loans payable within one year _____
- (4) Salaries and wages payable _____
- (5) Payroll taxes payable _____
- (6) Accrued taxes _____
- (7) Deferred income _____
- (8) Patient trust funds due to patients _____
- (9) Intercompany payables _____
- (10) Other current liabilities (specify)

- (11) Total Current Liabilities -
 Add items (1) through (10) \$_____

b. Long Term Liabilities

- (1) Mortgages payable beyond one year \$_____
- (2) Notes payable beyond one year _____
- (3) Unsecured loans _____
- (4) Loans from owners _____
- (5) Other long term liabilities (Specify)

C. Balance Sheet (continued)

- (6) Total Long Term Liabilities
 Add items (1) through (5) \$_____

c. Total Liabilities - Add items a(11) and b(6) \$_____

3. Capital (Owner's Equity or Fund Balance)

a. Net Worth:

- (1) Individual \$_____
- (2) Partnership _____

(Rule 1200-13-6-.08, continued)

(3) Corporation

(a) Capital stock
(at par or stated value) _____

(b) Paid in capital _____

(c) Treasury stock _____

(d) Retained earnings _____

(4) Fund Balance (Nonprofit) _____

b. Total Capital - Add items a(1) through a(4) \$_____

4. Total Liabilities and Capital
(Section C, item 2c plus item 3b) \$_____D. *Summary Statement of Income, Expense, and Retained Earnings*1. Income ²⁸

a. Gross Routine Service Charges

	(1) Room & Board	(2) Other Covered Services	(3) (1) + (2) Total
(1) Medicare Skilled	\$_____	\$_____	\$_____
(2) Medicaid - NF2	\$_____	_____	_____
(3) Medicaid - NF1	\$_____	_____	_____
(4) Private - NF1	\$_____	_____	_____
(5) Private - NF2	\$_____	_____	_____
(6) Medicaid - ICF/MR	\$_____	_____	_____
(7) Private - ICF/MR	\$_____	_____	_____

D. *Summary Statement of Income, Expense, and Retained Earnings (continued)*

(8) Other NF1	_____	_____	_____
(9) Other NF2	_____	_____	_____
(10) TOTAL ROUTINE NF CHARGES Add items (1) through (9)	\$_____	\$_____	\$_____
(11) Non-NF routine charges			\$_____

(Rule 1200-13-6-.08, continued)

(12) TOTAL ROUTINE CHARGES - Add items (10) and (11) \$ _____

b. Other Income

(1) Pharmacy \$ _____

(2) Laboratory _____

(3) X-ray _____

(4) All therapies _____

(5) Other ancillaries (Specify)

(6) Cable TV income _____

(7) Rental income from non-routine nursing
home operations _____(8) Rental income from non-nursing
home facilities _____

(9) Non-routine barber/beauty shop income _____

(10) Employee, owner, and guest meals _____

(11) Vending machine income _____

(12) Non-routine laundry income _____

(13) Interest and investment income on other
than funded depreciation accounts
(Attach Itemized Schedule) _____

(14) Interest on funded depreciation deposits _____

(15) Contributions, donations, and grants _____

D. *Summary Statement of Income, Expense, and Retained Earnings (continued)*(16) Miscellaneous income
Attach Itemized Schedule) _____(17) Total Other Income
Add items (1) through (16) \$ _____

c. Total Income Add items a(12) and b(17) \$ _____

2. Deductions from Revenue:

a. Bad Debt Expenses

(Rule 1200-13-6-.08, continued)

(1) Applicable to Medicaid NF1 patients	\$_____	
(2) Applicable to other patients	_____	
(3) Other bad debts (Specify) _____	_____	
b. Contractual Allowance and Other Adjustments		
(1) Applicable to Medicaid NF1 patients	\$_____	
(2) Applicable to other patients	_____	
(3) Other (Specify) _____	_____	
c. Deductions from Revenue Add items 2a through 2b		_____
3. Net Revenue Item 1c minus 2c		_____
4. Operating Expense (Item F.21.)		_____
5. Profit or (Loss) Item 3 minus 4		\$_____
6. Additions and Deductions:		
a. Additions other than revenue (Specify)		
(1) _____	\$_____	
(2) _____	_____	
(3) Total Additions	\$_____	
b. Deductions		
(1) Dividends	_____	
(2) Withdrawal of earnings	_____	
(3) Other (Specify) _____	_____	
(4) Total Deductions	_____	
D. <i>Summary Statement of Income, Expense, and Retained Earnings (continued)</i>		
c. Net Additions Over Deductions Item a(3) minus b(4)		\$_____
7. Increase or (Decrease) in Balance of Retained Earnings for the Period - Add items 5 and 6c		\$_____
8. Beginning Balance (If different from prior year ending balance, explain)		\$_____

(Rule 1200-13-6-.08, continued)

9. Retained Earnings (or Fund Balance) at the end of the reporting period - Add items 7 and 8

\$ _____

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.*^{9,10,11}

1. Statement of Compensation to Owners¹³

Name (1)	Title (2)	Proprietors & Partners Percent Share of Operating Profit or (Loss)	Corporate Shareholders Percent of Providers Stock Owned
		(3)	(4)
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

Lines a through d continued below.

Percentage of Customary Work Week Devoted to this Facility (5)	Inclusive Dates of Employment at this Facility (6)	Amount of Compensation Included in Operating Costs for the Period (7)	Where in Section F is the Compensation included? (8)
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

*Attach a statement describing actual duties performed by each individual listed.

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.*^{9,10,11} (continued)

2. Statement of Compensation Paid to Administrators (Other than Owners) and Relatives of Owners and Administrators^{13,14}

Name (1)	Title (2)	Relationship to Owners, Administrators, or Assistant Administrators (3)	Percentage of Customary Work Week Devoted to this Facility (4)
a. _____	_____	_____	_____
b. _____	_____	_____	_____

(Rule 1200-13-6-.08, continued)

c. _____

d. _____

Lines a through d continued below.

Inclusive Dates of Employment at this Facility _____ (5) _____	Amount of Compensation Included in Operating Costs for the Period _____ (6) _____	Where in Section F is the Compensation included? _____ (7) _____
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____

*Attach a statement describing actual duties performed by each individual listed.

3. Intercompany Transfers and Transactions with Related Organizations, Including Home Office and Parent Companies ^{15,16,17}

Note: A Home Office cost report and attached apportionment schedules must be filed before these costs can be considered allowable.

E. Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation. ^{9,10,11} (continued)

a. List all expenses included in Section F which were paid or accrued to a Related Organization:

Name of Organization	Amount	Department or Account in Section F
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Attach a schedule listing

(1) All intercompany transfers and transactions between the facility and any Related Organization.

(2) The names of all business entities

(a) that are related organizations, and

(Rule 1200-13-6-.08, continued)

- (b) with whom the provider, during the reporting period, had more than \$25,000 in business transactions or transacted 5 percent or more of the total operating expenses of the provider, whichever is less. (See footnote 12)

- (3) Names, titles, positions, duties, and total compensation received by all members of Boards of Directors, Corporation Officers, Administrators, Owners, and any other key employees and their relatives, who constructively own 5 percent or more, of any of the organizations in (2) above, and the percentage of constructive ownership by each person listed. If none, so indicate.

4. List the name(s) and address(es) of the owner(s) of the land and buildings. ^{9,10,11}

5. If the land and buildings are rented, state the relationships (family and business) of the operator(s) of the nursing home to the owner(s) of the land and building, if any. If not related, so state. ^{9,10,11}

- E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.* ^{9,10,11} (continued)

6. Daily Room & Board Charge Rates

	NF1	NF2	ICF/MR
Private Room Rate:			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
Semi-Private Room Rate:			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
Other Room Rates (Specify):			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____

effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____

(Rule 1200-13-6-.08, continued)

Note: Any rate or charge change made during the year should be listed. Please do not include a charge range.

If charges have changed since the close of the accounting period, explain: _____

7. Patient NonEmergency Transportation

- a. Does your facility provide or arrange to provide for non-emergency patient transportation?

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.*^{9,10,11} (continued)

- b. If you arrange for the transportation, provide the name of the organization and the amount of expense included in Section F that was paid for the service.

- c. If your facility provides the transportation, do you bill Medicaid separately for the service?

If yes, what is the amount of income and where is it included in Section D?

F. *Operating Expenses:* (Expenses per General Ledger)^{4,18,19}

*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
1. Administration and General			
a. Salary of administrator	\$_____		_____
b. Other compensation to administrator	_____		
c. Other administrative salaries	_____		_____
d. Office supplies and printing	_____		

(Rule 1200-13-6-.08, continued)

- e. Communications _____
- f. Travel (Motor Vehicle) _____
- g. Travel (Other) _____
- h. Advertising ¹⁸ _____
- i. Licenses, dues, and subscriptions _____
- j. Professional training and education _____

F. *Operating Expenses:* (Expenses per General Ledger) ^{4,18,19} (continued)

*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
k. Conference registration and fees	_____		
l. Accounting and auditing	_____		
m. Legal services	_____		
n. Pharmacy consultant services	_____		
o. Other professional services	_____		
p. Management fees	_____		
q. Franchise tax and filing fees	_____		
r. Public relations ¹⁸	_____		
s. Excise taxes	_____		
t. Insurance (excluding amounts properly included in item 18d)	_____		
u. Utilization review fees	_____		
v. Other ¹⁸ _____	_____		
w. Total Add items a through v		\$_____	

2. Employee Benefits

- a. Social Security and Unemployment Insurance _____
- b. Other employee benefits
(Attach Itemized Schedule) _____

(Rule 1200-13-6-.08, continued)

c. Total - Add items a and b _____

3. Dietary

a. Dietary salaries _____

b. Raw food _____

F. *Operating Expenses*: (Expenses per General Ledger) ^{4,18,19} (continued)

*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule)	_____		
e. Other ¹⁸ _____	_____		
f. Total Add items a through e		_____	
4. Housekeeping			
a. Housekeeping salaries	\$ _____		
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		
d. Other ¹⁸ _____	_____		
e. Total - Add items a through d		_____	
5. Laundry and Linen			
a. Laundry and linen salaries	_____		
b. Linen and bedding	_____		
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule)	_____		
e. Other ¹⁸ _____	_____		
f. Total - Add items a through e		_____	
6. Plant Operation and Maintenance			
a. Operation and maintenance salaries	_____		
b. Fuel (Heating)	_____		

(Rule 1200-13-6-.08, continued)

F. *Operating Expenses:* (Expenses per General Ledger) ^{4,18,19} (continued)

*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
c. Gas	_____		
d. Electricity	_____		
e. Water and sewage	_____		
f. Supplies	_____		
g. Purchased services (Attach Itemized Schedule)_____			
h. Repairs	_____		
i. Other ¹⁸ _____	_____		
j. Total Add items a through i		_____	
7. Medical and Nursing			
a. Salaries Medical Director	_____		_____
b. Salaries Registered Professional Nurses (RNs) _____			_____
c. Salaries Licensed Practical Nurses (LPNs)	_____		_____
d. Salaries Attendants, orderlies, and aides	_____		_____
e. Salaries Other nursing personnel	_____		_____
f. Supplies	_____		
g. Purchased services (Attach Itemized Schedule)_____			
h. Routine medical supplies ²⁰	_____		
i. Other ¹⁸ _____	_____		
j. Total Add items a through i		_____	
8. Physicians Care (Excluding Medical Director)			
a. Physicians salaries or fees	\$ _____		_____

F. *Operating Expenses:* (Expenses per General Ledger) ^{4,18,19} (continued)

*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
b. Other salaries or fees	_____		_____
c. Other ¹⁸ _____	_____		
d. Total Add items a through c		\$ _____	
9. Pharmacy (Excluding consultant fees)			
a. Pharmacy salaries or fees	_____		_____
b. Drugs and pharmaceuticals	_____		
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule) _____			
e. Other ¹⁸ _____	_____		
f. Total Add items a through e		_____	
10. Laboratory			
a. Laboratory salaries or fees	_____		_____
b. Supplies _____			
c. Purchased services (Attach Itemized Schedule) _____			
d. Other ¹⁸ _____	_____		
e. Total Add items a through d		_____	
11. X-ray			
a. X-ray salaries or fees	_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule) _____			

F. *Operating Expenses:* (Expenses per General Ledger)^{4,18,19} (continued)

*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
d. Other ¹⁸ _____	_____		
e. Total Add items a through d		_____	
12. Recreational Activities			
a. Recreational salaries	_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)_____			
d. Other ¹⁸ _____	_____		
e. Total Add items a through d		_____	
13. Social Service			
a. Social service salaries	_____		_____
b. Other ¹⁸ _____	_____		
c. Total Add items a and b		_____	
14. Physical Therapy			
a. Salaries	\$_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)_____			
d. Other ¹⁸ _____	_____		
e. Total Add items a through d		\$_____	
15. Psychiatric Services ²¹			
a. Salaries	_____		_____
b. Purchased services (Attach Itemized Schedule)_____			
F. <i>Operating Expenses:</i> (Expenses per General Ledger) ^{4,18,19} (continued)			
*Enter all amounts in whole dollars.			

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
c. Other ¹⁸ _____	_____		
d. Total Add items a through c		_____	
16. Psychological Services ²¹			
a. Salaries	_____		_____
b. Purchased services (Attach Itemized Schedule) _____			
c. Other ¹⁸ _____	_____		
d. Total Add items a through c		_____	
17. Medical Records			
a. Salaries	_____		_____
b. Supplies	_____		
c. Other ¹⁸ _____	_____		
d. Total Add items a through c		_____	
18. Property Expense			
a. Real estate taxes on property used only for nursing home purposes	_____		
b. Rent or lease fee on buildings or equipment used only for nursing home purposes	_____		
c. Interest expense on buildings or equipment used only for nursing home purposes	_____		
d. Insurance on property used only for nursing home purposes	_____		
e. Total Add items a through d		_____	
F. <i>Operating Expenses:</i> (Expenses per General Ledger) ^{4,18,19} (continued)			
*Enter all amounts in whole dollars.			

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
19. Depreciation and Amortization ³⁰ (Complete Schedule L)			
a. Land improvements	_____		
b. Buildings	_____		
c. Leasehold/building improvements	_____		
d. Fixed equipment	_____		
e. Movable equipment	_____		
f. Automotive equipment	\$_____		
g. Other depreciation (Specify on Schedule L)	_____		
h. Amortization of pre-opening costs	_____		
i. Amortization of organization cost	_____		
j. Other Amortization (Specify on Schedule L)	_____		
k. Total Add items a through j		\$_____	
20. Other Expenses (Specify) (Attach schedule if additional space is needed)			
a. Salaries _____	_____		_____
b. Vending machines	_____		
c. Purchased barber and beauty services	_____		
d. Cable TV (not beneficial to all patients)	_____		
e. Other interest not included on line 18 (Include on Schedule M)	_____		
f. Annual nursing home privilege tax	_____		
g. Other ¹⁸ _____	_____		
F. <i>Operating Expenses:</i> (Expenses per General Ledger) ^{4,18,19} (continued)			
*Enter all amounts in whole dollars.			

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense _____(2)_____	Totals _____(3)_____	FTEs ¹⁸ _____(4)_____
h. Total Add items a through g	_____		
21. Total Operating Expense Add totals in column 3, items 1 through 20		\$_____	_____

G. Adjustments for Calculating Allowable Routine Operating Expense²²

1. Total Amount of Expenses Per Books (Total should equal amount under Section F, Item 21) \$_____
2. Adjustments to be made (Deduct only items included in item 1 above)

	<u>Description of Expense or Income</u>	<u>Base</u> ²³	<u>Amount</u>
a.	Research and medical education	_____	\$_____
b.	Vending machines, concessions, etc.	_____	_____
c.	Non-routine barber and beauty shop income	_____	_____
d.	Non-routine medical and surgical supply income	_____	_____
e.	Non-routine laundry income	_____	_____
f.	Applicable miscellaneous income	_____	_____
g.	Interest and investment income (limited to interest expense)	_____	_____
h.	Telephone charges paid for by patients, guests, employees, and others	_____	_____
i.	Guest, owner, and employee meals not considered as a part of compensation; and the cost of free meals to guests	_____	_____
j.	Drugs, supplies, or other services purchased by non-patients	_____	\$_____
k.	Income from rental of facility furniture and equipment to patients and non-patients	_____	_____

G. Adjustments for Calculating Allowable Routine Operating Expense²² (continued)

(Rule 1200-13-6-.08, continued)

	<u>Description of Expense or Income</u>	<u>Base</u> ²³	<u>Amount</u>
l.	Rental, maintenance, insurance, depreciation, taxes, and other expenses of non-nursing home facilities (attach supporting schedules)	_____	_____
m.	Bad debts or provisions therefor, charity and courtesy allowances included in operating expenses	_____	_____
n.	Expenses applicable to outpatients	_____	_____
o.	Amounts collected for and paid to pharmacists, physicians, and other professional individuals	_____	_____
p.	Non-allowable purchased services	_____	_____
q.	Salaries or fees paid to physicians for treatment of individual patients and related expenses	_____	_____
r.	Pharmacy (Amount shown in Section F, Item 9f as well as any other applicable amount)	_____	_____
s.	Laboratory (Amount shown in Section F, Item 10e)	_____	_____
t.	X-ray (Amount shown in Section F, Item 11e as well as any other applicable amount)	_____	_____
u.	Cable TV (Other than those in lounge or lobby for general benefit of all patients). (Amount shown in Section F, Item 20d as well as any other applicable amount)	_____	_____
v.	Facilities or accommodations furnished owners, administrators, and other non-patients not considered compensation. ²⁴ (Attach computation sheets)	_____	_____
w.	Indirect expenses apportioned to Ancillary Departments (Amount in Section H, Item 20)	_____	_____
G.	<i>Adjustments for Calculating Allowable Routine Operating Expense</i> ²² (continued)		
x.	Related organization:		
	(1) Expense paid to a related organization	\$ _____	
	(2) Cost of services by the related organization	\$ _____	
	(Difference between (1) and (2) is the amount to be adjusted) (Attach supporting cost data and schedules)		

(Rule 1200-13-6-.08, continued)

	<u>Description of Expense or Income</u>	<u>Base</u> ²³	<u>Amount</u>
y.	Excess owner's compensation	_____	_____
z.	Excise taxes (Amount shown in Section F, Item 1s)	_____	_____
aa.	Cost of items billed and collected from Medicare Part B on behalf of Medicaid NF1 recipients	_____	_____
bb.	All other items or services which are not covered by NF1 Medicaid services ²⁵	_____	_____
cc.	Other adjustments (Specify on an attached itemized schedule)	_____	_____
dd.	Total Add items a through cc		\$_____
3.	Total Allowable Routine Operating Costs Item G1 minus G2dd		\$_____

H. Allocation of Cost to Routine, Ancillary, and Extra Charge Areas ^{26,27}

<u>Cost Item</u>	<u>Total</u> <u>(1)</u>	<u>Routine</u> <u>(2)</u>	<u>Pharmacy</u> <u>(3)</u>	<u>Laboratory</u> <u>(4)</u>	<u>Radiology</u> <u>(5)</u>	<u>Other</u> <u>Ancillary</u> <u>(6)</u>
1. Administration & General (F1) Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
2. Employee Benefits (F2) Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____

H. Allocation of Cost to Routine, Ancillary, and Extra Charge Areas ^{26,27}

<u>Cost Item</u>	<u>Total</u> <u>(1)</u>	<u>Routine</u> <u>(2)</u>	<u>Pharmacy</u> <u>(3)</u>	<u>Laboratory</u> <u>(4)</u>	<u>Radiology</u> <u>(5)</u>	<u>Other</u> <u>Ancillary</u> <u>(6)</u>
3. Dietary (F3) Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
4. Housekeeping (F4) Allocation						

(Rule 1200-13-6-.08, continued)

Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
5. Laundry and Linen (F5) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
6. Plant Operation and Maintenance (F6) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
7. Medical and Nursing (F7) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
8. Recreational Activities (F12) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
9. Social Services (F13) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
10. Physical Therapy (F14) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
11. Psychiatric Services (F15) Allocation Statistics	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
12. Psychological Services (F16) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
13. Medical Records (F17) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
14. Property Expense (F18) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$
15. Building Depreciation (F19a-c) Allocation Statistics Cost	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$	<u> </u> \$

(Rule 1200-13-6-.08, continued)

<u>Cost Item</u>	<u>Total (1)</u>	<u>Routine (2)</u>	<u>Pharmacy (3)</u>	<u>Laboratory (4)</u>	<u>Radiology (5)</u>	<u>Ancillary (6)</u>
16. Equipment and Other Depreciation (F19d-g) Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
17. Amortization (F19h-j) Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
18. Any Other Shared Cost Allocation Statistics Cost	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
19. Totals	\$_____	\$_____	\$_____	\$_____	\$_____	\$_____
20. Allocated Ancillary Costs (Columns 3, 4, 5, and 6)	\$_____					

I. *Total Ancillary and Extra Charge Area Costs*²⁶

	<u>Pharmacy</u>	<u>Laboratory</u>	<u>Radiology</u>	<u>Other Ancillary</u>
1. Direct Costs (F8, F9, F10, etc.)	\$_____	\$_____	\$_____	\$_____
2. Indirect Costs (H19)	_____	_____	_____	_____
3. Total	\$_____	\$_____	\$_____	\$_____

J. Summary of Ancillary Charges²⁸

	(a) <u>Medicare Skilled</u>	(b) <u>Medicaid NF2</u>	(c) <u>Private</u>	(d) <u>Total</u>
1. Pharmacy	\$_____	\$_____	\$_____	\$_____
2. Laboratory	_____	_____	_____	_____
3. X-ray	_____	_____	_____	_____
4. All therapies	_____	_____	_____	_____
5. Other ancillaries (Specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Rule 1200-13-6-.08, continued)

6. Totals - Add items 1 through 5

\$ _____ \$ _____ \$ _____ \$ _____

K. Calculation of Expenses Applicable to NF1 Program (Reimbursable Cost) ²⁹

- a. Facilities rendering one level of care (NF1 only)

(1)	(2)	(3)	(4)	(5)
Total Nursing Facility Days (B.4.j.)	Medicaid NF1 Inpatient Days (B.4.c.)	% Medicaid NF1 Days to Total Days (Col. 2 / Col. 1)	Total Allowable Routine Operating Costs (G.3.)	Expenses Applicable to NF1 Program (Col. 3 x Col. 4)
=====	=====	=====	=====	=====

- b. Facilities rendering more than one level of care.

(1)	(2)	(3)	(4)	(5)
Total Routine NF Charges (D.1.a.10.)	Routine Charges to Medicaid NF1 Patients (D.1.a.3.)	% Medicaid NF1 Charges to Total Charges (Col. 2 / Col. 1)	Total Allowable Routine Operating Costs (G.3.)	Expenses Applicable to NF1 Program (Col. 3 x Col. 4)
=====	=====	===== %	\$ =====	\$ =====

L. Depreciation and Amortization Schedule ³⁰

<u>Asset</u>	<u>Cost</u>	<u>Date Acquired</u>	<u>Estimated Useful Life</u>	<u>Salvage Value</u>	<u>Method</u>	<u>Current Period Depreciation</u>
Land Improvements	\$ _____	_____	_____	\$ _____	S/L	\$ _____
Building	_____	_____	_____	_____	S/L	_____
Leasehold/Building Improvements	_____	_____	_____	_____	S/L	_____
Movable Equipment	_____	_____	_____	_____	S/L	_____
Other Depreciable Assets	_____	_____	_____	_____	S/L	_____
	_____	_____	_____	_____	S/L	_____
	_____	_____	_____	_____	S/L	_____
Totals	\$ =====					\$ =====

(Rule 1200-13-6-.08, continued)

<u>Amortization</u>	<u>Original Amount</u>	<u>Starting Date</u>	<u>Amortization Period</u>	<u>Method of Amortization</u>	<u>Current Period Amortization</u>
Pre-opening Cost	\$ _____	_____	<u>5 years</u>	<u>S/L</u>	\$ _____
Organization Cost	\$ _____	_____	<u>5 years</u>	<u>S/L</u>	\$ _____
Other (Specify)	\$ _____	_____	_____	<u>S/L</u>	\$ _____
_____	\$ _____	_____	_____	<u>S/L</u>	\$ _____
Totals	\$ _____				_____

M. *Loans, Mortgages, and Notes* ¹⁵

- List individually all loans, mortgages, and notes made in the name of the facility, operators, and/or owners of the facility, for which the related interest expense has been included as an allowable cost. If the amount of previously outstanding loans, mortgages, or notes was increased during the period, list amount and date of increase. State the name of the lender (optional, if not identified by name, enter some code which will be traceable to the provider's records), date of loan, amount of principal, and the amount of interest for the accounting period. List new obligations incurred during this period in item 2. below.

<u>Name of Lender</u>	<u>Date of Loan</u>	<u>Beginning Balance</u>	<u>Ending Balance</u>	<u>Current Period Interest Expense</u>
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total Interest Expense for Item 1 _____

- For each new obligation incurred during this reporting period state the name of lender (optional, if not identified by name, enter some code which will be traceable to the provider's records), amount of the new obligation, interest expense included in Section F, the disposition of the proceeds of the loan, and the date the obligation was incurred. Do not duplicate items in 1 above.

(Rule 1200-13-6-.08, continued)

<u>Name of Lender</u>	<u>Purpose for Loan</u>	<u>Date of Loan</u>	<u>Original Amount</u>	<u>Ending Amount</u>	<u>Current Period Interest Expense</u>
_____	_____	_____	\$_____	\$_____	\$_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Total Interest Expense for Item 2 \$_____

Total Interest Expense - Add items in 1 and 2 \$_____

N. Statement of Equity Capital³¹

	<u>Date</u>	<u>Amount</u>
1. Change in Equity Capital (Dates are required for c, d, and e)		
a. Equity Capital Beginning of Period		\$_____
b. Net Income (Loss) for the Period (Item D.5.)		_____
c. Capital Investments (Withdrawals) during the period (Attach schedule if more than one entry)		_____
_____	_____	_____
d. Gain (Loss) on Fixed Assets (Attach schedule if more than one entry)		_____
_____	_____	_____
e. Other Increases (Decreases) (Specify Attach schedule if more than one entry)		_____
_____	_____	_____
f. Equity Capital - End of Period		\$_____
2. Reconciliation of Equity Capital with Total Capital		
a. Total Capital (Item C.3.b.)		\$_____
b. Additions (Deductions) (Identify each entry)		_____
_____	\$_____	_____
_____	_____	_____

(Rule 1200-13-6-.08, continued)

c. Equity Capital - End of Period

\$_____

O. *Certification by Owner, Officer, or Administrator of Facility*

I, _____, _____ of the
(Name) (Title)

_____, _____, _____
(Name of Facility) (City) (State)

do certify that I have examined the attached report for the fiscal period beginning _____, 19____, and ending _____, 19____, the accompanying *Footnotes and Instructions and Accounting Principles*, and that to the best of my knowledge and belief, this report is a true and correct statement of the information required, and that charges and expenses for services provided to Medicaid Program recipients were in accordance with applicable state and federal regulations. I understand that any false claims, statements, or documents, or the concealment of a material fact may lead to prosecution under applicable Federal or State Laws.

Date _____, 19____
Signature of Authorized Representative of Facility

Typed Name of Authorized Representative

Title

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original chapter filed January 12, 1988; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed August 17, 1995; effective October 30, 1995. Amendment filed January 21, 2000; effective April 5, 2000.

1200-13-6-.09 FOOTNOTES AND INSTRUCTIONS FOR THE NURSING FACILITY LEVEL I COST REPORT.

(1) General

1. Enter the NF-1 Provider number as issued by the Tennessee Department of Health and the NF-2 Provider number as issued by Medicare. Providers with numbers other than NF-1 and NF-2 may include them on the Level II line.
2. Enter name of facility exactly as shown on the license (permit) to operate issued by the Tennessee Department of Health.
3. Cash basis accounting is not acceptable for purposes of this report. All amounts must be reported in whole dollars.

(Rule 1200-13-6-.09, continued)

4. Adequate financial records, statistical data, and source documents must be maintained for proper determination of costs under the program.
- B. Statistical Data
5. All statistics to be reported in this section will be for the same period as the accounting period covered by this report.
6. Possible bed days should be the sum of the count of the number of licensed beds for each day of the accounting period.
7. An inpatient day is that period of service rendered a patient between the census taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day. All days charged for must be included in the patient day statistics including leave days, reserved bed days, etc. A census will be recorded each day during the accounting period. All such records must be available for verification by the Comptroller's Office. All inpatient days must be identified by the categories indicated.
8. Report all meals provided to patients, employees, guests, and owners. The cost of meals provided to owners must be included in compensation stated in Section E. Adequate meal records must be maintained.
- E. Ownership of Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, Including Home Office Costs; Charge Rates; and Patient Transportation
9. Controlling interest is defined as a person or entity that:
 - (a) has an ownership interest totaling five percent (5%) or more in a disclosing entity,
 - (b) has an indirect ownership interest equal to five percent (5%) or more in a disclosing entity,
 - (c) has a combination of direct and indirect ownership interest obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity,
 - (d) is an officer or director of a disclosing entity that is organized as a corporation, or
 - (e) is a partner in a disclosing entity that is organized as a partnership.

Indirect ownership interest is defined as any ownership interest in an entity that has an ownership interest in the disclosing entity. This includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. EXAMPLE: A owns ten percent (10%) of the stock of Corporation B which owns eighty percent (80%) of the stock of the disclosing entity. A's interest is an eight percent (8%) indirect ownership interest in the disclosing entity and must be disclosed.

The amount of ownership, mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. EXAMPLE: A owns ten percent (10%) of a note secured

(Rule 1200-13-6-.09, continued)

by sixty percent (60%) of the provider's assets. A's interest in the provider's assets is six percent (6%) and must be disclosed.

10. Disclosing entities are defined as hospitals, skilled nursing facilities, clinical laboratories, renal disease facilities, health maintenance organizations, and rural health clinics (as established by P. L. 95210) under Title XVIII (Medicare), entities (other than practitioners or groups of practitioners) that furnish or arrange for the furnishing of services under the Title XIX or Title V (Children's Special Service) programs; fiscal intermediaries, fiscal agents, and carriers participating in Medicare or Medicaid; and providers of health related services under the Title XX program.
11. Information relating to ownership shall be maintained at the facility and available for audit and upon request at any time.
12. The amounts of business transacted with entities that are not related entities need not be disclosed in the cost report. However, in the event of a request, the disclosure of the amounts and the ownership of the business entity with whom the provider transacted business of more than \$25,000 or five percent or more of the total operating expenses of the provider, whichever is less, may be required within 30 days of the request.
13. For reimbursement purposes, a reasonable allowance or compensation for services of an owner or persons related to an owner is an allowable cost, provided the services are performed in a necessary function. The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be related to patient care and pertinent to the operation and sound management of the institution.

Total compensation to such persons must be listed in Section E, Items 1 and 2. Where such amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits. All such costs included in Section F must be reported in Section E.

The Comptroller's Office will review these amounts and compare them with allowable compensation ranges and make necessary adjustments. The Comptroller will consider the duties, responsibilities, and managerial authority of the person as well as the services performed for other institutions and his engagements in other occupations. Only one fulltime position, or its equivalent will be allowed for each person. The duties performed, time spent, and compensation received by such a person must be substantiated by appropriate records. Allowable ranges can be found in Chapter 1200-13-6-.11.

14. Complete Section E, Item 2 only for individuals who are not owners of the facility. If the individual is related to any owner by blood or marriage, this relationship must be indicated in Column 3. See PRM, Part 1, Section 902.5.
15. All loan transactions with related parties as defined in footnotes 9 and 10 shall be fully disclosed in Section E and the corresponding interest expense shall be disallowed in Section G.
16. The hospital parent or a hospital-based nursing home shall not be considered as a home office if the hospital is a regular provider in the Medicaid hospital program and files the appropriate Medicare-Medicaid hospital cost report in a timely manner. Costs allocated to the nursing home on the hospital's Medicare-Medicaid cost report are includable in Section F of this cost report. These amounts do not have to be audited by the Certified Public Accountant or licensed Public Accountant if significant portions of the corresponding expenses before allocation are apportioned to the hospital and prior approval is received from the Comptroller's Office. The

(Rule 1200-13-6-.09, continued)

report by the Certified Public Accountant must disclose the amounts allocated to the hospital and nursing facility, the bases used, and the corresponding figures which were not included in the audit.

17. Home Office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) may be allowable to the extent they are reasonable. Home Office costs or related organization costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable costs when allocated to providers. Nursing facility cost reports will not be processed until the home office costs are submitted.

F. Operating Expenses

18. Itemized schedules must be attached to support advertising, public relations, "other," and "purchased services" accounts. Amounts not supported will be disallowed.

Enter in the appropriate classification the number of personnel employed full-time as of the end of the fiscal period covered by this statement. Report the fulltime equivalent (FTE) of all personnel working in the particular classification. For example, if five people are employed full-time as LPNs, one person is employed as an LPN one day per week (eight hours per day), and another person works as an LPN two days per week (eight hours per day), the total LPNs to be reported should be 5.6 full-time equivalent employees. The number of personnel in each particular classification under Section F, Column (4), "FTEs", must coincide with the salaries reported in each particular classification of Section F, Column (2), "Amount of Expense". Payroll records are to be available for verification by the Comptroller's Office.

19. All facilities should properly identify and include in Section F. "Operating Expense," the cost of providing to all patients the medical supplies, equipment, and services specified by the Department of Health as covered services. These are items and services (per the Department of Health contract with all facilities) for which the facility may not receive extra payments from Medicaid patients, their relatives or others.
20. Include the cost of covered supplies only. Do not include drugs or pharmacy items that are not covered by the NF-1 program. Drugs and pharmacy should be included in item F.9.
21. Psychiatric and Psychological Services can be provided only to ICF/MR patients in an ICF/MR licensed facility.
22. The purpose of Section G, "Adjustments for Calculating Allowable Routine Operating Expense" is to determine the cost of room and board, nursing care, medical and nursing supplies, and other services as specified and defined by the Department of Health as NF-1 covered services. Consequently, the cost of any items or services not a part of the cost of providing NF-1 covered services included in Section F, "Operating Expense" are to be deducted from operating expenses in Section G. Accounting and other records of participating facilities are subject to audit and verification by the Comptroller's Office for proper determination of cost of covered services. In addition to the items specifically identified in Section G, the following are also expenses not considered a part of the cost of providing routine service, and should be deducted. This list is not to be considered all inclusive. Generally, where an item is not specifically addressed, Medicare reimbursement principles apply.

a. Interest paid:

- (1) On borrowed funds used for a non-allowable expenditure.

(Rule 1200-13-6-.09, continued)

- (2) On borrowed funds which create excess working capital.
 - (3) On borrowed funds used for investing in other than provider's health care operations.
 - (4) To partners (owners), stockholders, or related organizations or relatives.
 - (5) On borrowed funds used to fund depreciation.
- b. Any imputed value of produce, supplies or space donated to the provider.
- c. Purchase discounts, cash discounts, trade discounts, quantity discounts or allowances.
- d. Purchase refunds or rebates.
- e. Costs which are not necessary or related to patient care.
- f. Costs of non-competing covenant agreements.
- g. Insurance premiums paid on the lives of owners, officers, and key personnel, if the provider is the direct or indirect beneficiary. If another party is beneficiary, the premiums are to be considered as compensation to the respective owner, officer, or key employee and should be disclosed separately.
- h. Cost of personal comfort items and other non-covered items, as may be specified and defined by the Department of Health.
- i. Cost of luxury items such as TV, telephone, and radio in patient rooms. (This does not include those items placed in lounges or recreation rooms to be used by all patients).
- j. Any fines, penalties, or interest paid on any tax payments or interest charges on overdue payables.
- k. Federal, State, or local income taxes, or excess profit taxes.
- l. Any taxes for which exemptions are available but not taken.
- m. Sales taxes collected by the provider and remitted to the state.
- n. Real estate taxes and other expenses on property purchased and held for investment or expansion, and not used in rendering patient service.
- o. Self employment taxes applicable to owners, partners, members of joint ventures, etc.
- p. Casualty and other losses such as liability, theft, larceny, embezzlement, that are insurable but uninsured. (When insured, the insurance premiums and cost of deductibles for these losses are allowable). Medicare principles must apply.
- q. Advertising costs incurred:
 - (1) To raise funds for the provider.
 - (2) Which are designed to encourage physicians to utilize the provider's facilities in their capacity as an independent practitioner.

(Rule 1200-13-6-.09, continued)

- (3) In connection with the issuance of the provider's own stock or sale of stock held by the provider in another corporation.
 - (4) Which seek to increase patient population or utilization of the provider's facilities by the general public.
 - r. Membership dues, initiation fees, subscription costs or special assessments paid to Social, Fraternal, or other organizations whose activities are unrelated to the profession or business of their members.
 - s. Cost of private duty nurses and attendants.
 - t. Travel expenses which are personal in nature, not proper or related to patient care, and auto expenses applicable to non-business uses of the vehicles. Detailed justification for out of state travel must be retained for audit verification.
 - u. Any other costs which are identified and specified as non-allowable by the Medicaid Program manuals, or federal or state rules or regulations.
23. The cost of excludable expenses should be deducted. In the relatively few instances where such costs cannot be adequately determined, deduct the revenue received therefrom. If the amount shown is revenue enter "R" as the base.
24. Cost of facilities furnished to owners, administrators, and other non-patients must be determined on a reasonable basis. Where the nursing home has no plan for determining reasonable charges for these facilities, the patient charge schedule may be used by the Comptroller of the Treasury in arriving at the amount of exclusion.
25. In Section G. Item 2bb any costs or expenses included in Section F, "Operating Expense," for the items or services for which Medicaid NF-1 patients may be charged extra by the facility in addition to the established reimbursable cost rate of the facility are to be deducted from operating expense.
26. Facilities with no ancillary or extra charge areas should omit Sections H and I.

H. Allocation of Cost to Routine, Ancillary and Extra Charge Areas

(Facilities with no ancillary or extra charge areas can omit this section).

27. The statistical bases below shall be used to apportion indirect costs to ancillary and extra charge areas unless prior approval is obtained in writing from the Comptroller of the Treasury.

<u>Cost Item</u>	<u>Basis</u>
1. Administration and General	Direct Costs (Section F)
2. Employee Benefits	Salaries
3. Dietary	Meals Served
4. Housekeeping	Square Feet or Actual Time Spent
5. Laundry	Pounds
6. Plant Operation and Maintenance	Square Feet
7. Medical and Nursing	Actual Cost
8. Recreational Activities	Time Spent
9. Social Services	Time Spent

(Rule 1200-13-6-.09, continued)

10. Property Expenses	Square Feet
11. Building Depreciation	Square Feet
12. Equipment and Other Depreciation	Dollar Value
13. Any other cost which should be allocated to Ancillary or Extra-Charge areas	Any reasonable basis approved by the State Comptroller's Office

The first line under each cost item to be allocated should show the allocation statistics used to apportion the total cost. The second line should show the costs after allocation. The allocation formula is:

$$\frac{\text{Area Statistic}}{\text{Total Statistic}} \times \text{Total Cost} = \text{Area Cost}$$

J. Patient Log Summary of Charges

28. Routine charges must be based on the facility's established daily charge rate before contractual allowances. Ancillary charges (Section J) do not apply to Medicaid NF1 recipients.
29. If a facility is rendering only one level of care, the percentages of costs of the NF-1 program will be determined as a percentage of Medicaid NF-1 patient days to total patient days (Section K, Item a). If a facility is rendering more than one level of care, the percentage of costs to the NF-1 program will be determined as a percentage of Medicaid NF-1 covered charges to total covered charges (Section K, Item b).

L. Depreciation and Amortization Schedule

30. The Depreciation and Amortization Schedule (Section L) must be completed. Fixed Asset cost must agree with the Fixed Asset cost by classification shown in Section C. Do not include land, as land is not considered a depreciable asset. The sum of the current period total amortization expense reported in Section L and the current year unamortized expense reported in Section C.1.c. (Items (5) and (6)) should equal the unamortized expense reported in Section C.1.c. (Items (5) and (6)) of the prior period cost report.

N. Statement of Equity Capital

31. Equity Capital means the net worth of a provider, excluding those assets not related to patient care. Specifically, Equity Capital, includes:
 - (a) a provider's investment in plant, property, and equipment (net of depreciation and associated long-term debt) related to patient care plus funds deposited by a provider who leases plant, property, and equipment related to patient care and is required by terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds) and
 - (b) net working capital maintained for necessary and proper operation of patient care activities.

Providers of chain organizations may assign an appropriate share of the equity capital of the home office to each facility. This assignment must be shown in the home office cost report. Debt representing loans from partners, stockholders, or related organizations and for which the interest is not an allowable cost shall be considered as equity capital and shall not be subtracted in the determination of (a) or (b) above.

(Rule 1200-13-6-.09, continued)

Investments, excess fixed assets, excess inventory, goodwill, loans to officers, owners, related organizations, or employees, uncollectible accounts and notes receivable, cash in excess of reasonable needs, and other assets, current or noncurrent, that are not reasonably related to patient care must be excluded from equity capital. Further, any capital expenditure that has not been approved by the Tennessee Health Facilities Commission or its successor agency in accordance with state law must be excluded from equity capital.

If the current year's beginning equity capital does not agree with the prior year's ending equity capital shown on the prior year's cost report, Section N, Statement of Equity Capital, a reconciliation must be attached.

All entries on line 1c, 1d, or 1e must be dated. Any changes in equity capital reported on lines 1c, 1d, and 1e must be supported by a schedule showing the date and amount of each change that has occurred during the period. **EXAMPLE** - If the beginning balance of a loan to an owner is \$10,000 and the ending balance is \$12,000 and the net change of \$2,000 occurred at different dates in different amounts (e.g., on February 15, the owner repaid \$1,000; on April 20, the owner repaid \$1,000; on June 10, the owner borrowed \$3,000; on September 5, the owner repaid \$2,000; and on October 20, the owner borrowed \$3,000) each increase and/or decrease during the period must be dated with the appropriate amounts reported separately. A return on equity amount cannot be calculated unless the changes are dated and the amounts are reported accurately.

32. Reserved

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed January 12, 1987; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed September 14, 1992; effective October 29, 1992. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed January 21, 2000; effective April 5, 2000.

1200-13-6-.10 MEDICAID NURSING FACILITY LEVEL I ACCOUNTING PRINCIPLES.

(1) Reimbursable Cost

This cost report must be completed in accordance with Medicare laws and principles of cost reimbursement as updated, except as specified in the cost report, the Footnotes and Instructions, and below:

- (a) Only the straight line method of computing depreciation is permitted.
- (b) Expenses related to disallowed capital expenditures such as depreciation, interest on borrowed funds, the return on equity capital in the case of proprietary providers, and repairs, are not allowable costs. Disallowed capital expenditures are those that have not been approved by the Tennessee Health Facilities Commissioner or its successor agency in accordance with state law.
- (c) Bad debt is not an allowable expense.
- (d) Costs may be included only for covered services as defined by the Department of Health.
- (e) The reimbursement of excessive capital costs arising from low occupancy is not permitted by the Medicaid NF-1 Program. Accordingly, Medicaid capital-related costs before application of any ceilings shall be recalculated according to the following scale:

(Rule 1200-13-6-.10, continued)

<u>Facility % Occupancy</u>	<u>Percent of Actual Allowable Costs</u>
80% and above	100%
75% to 79.999%	95%
70% to 74.999%	90%
65% to 69.999%	85%
60% to 64.999%	80%
55% to 59.999%	75%
50% to 54.999%	70%
Below 50%	60%

In addition, no incentive provisions will apply to providers with occupancies below 80%.

- (f) Assets not relating to patient care, uncollectible accounts and notes receivable, and advances or loans to owners are to be excluded from equity capital.
- (g) On a new lease effective after June 30, 1976, and renewal of such lease between either related or unrelated persons or entities, the lesser of rent on real property or equipment or the amount of the lessor's depreciation, interest, other allowable costs, and return on equity capital, in accordance with principle 2 of this section, will be considered on an item by item basis. Renewal of a lease negotiated before July 1, 1976, at the same rental amount or at an amount fixed or determinable according to conditions provided for in the original lease will not be considered a new lease according to this provision. This provision does not apply to the rental of equipment for periods of less than one year.

In cases where a provider leases a facility from a municipality or other governmental unit or agency at a nominal rental fee (e.g., \$1.00 per year) and the lease meets the Medicare criteria for the allowance of depreciation in lieu of rent, other costs to the governmental agency, which are otherwise allowable, may also be included in the reimbursable cost to the provider. When depreciation and other costs to the governmental agency are included by the provider, these costs must be specified as such and supporting documents must be available for audit in the same manner as the provider's own records.

- (h) In regard to the revaluation of assets, recovery of depreciation, and limitation of capital related costs on assets sold or transferred at a gain, the Tennessee Medicaid Program will allow the lesser of
 1. the asset's purchase price at the time of sale,
 2. the fair market value at the time of sale, or
 3. for bona fide arms length sales on and after July 1, 1988, the seller's allowable historical basis trended forward by the asset revaluation multipliers. These multipliers are computed by the Comptroller's Office based on the lesser of 50% of the Consumer Price Index or 50% of the Dodge Construction Index (measured from the seller's date of acquisition) and then reduced by the seller's accumulated depreciation to the time of sale.

Furthermore, for sales on and after July 1, 1988, the new provider's combination of down payment and loan principal cannot exceed the revalued basis. The down payment is applied to the revalued basis first, and the remaining amount is the allowable debt basis.

(Rule 1200-13-6-.10, continued)

The new provider's allowable useful lives on assets purchased cannot be less than the seller's remaining useful lives at the time of purchase. The provider of record (buyer) is responsible for providing the necessary initial information to the Comptroller's Office in order to make the necessary revaluation. In subsequent years' cost reports, the provider is responsible for maintaining records on assets subject to the revaluation limitation and must enter in Section G.2.cc. the excess of book depreciation and interest over the Medicaid allowable amount. Assets and debt acquired subsequent to and not related to the change of ownership are not subject to revaluation limitations. In no case can interest expense on assets subject to revaluation limits exceed actual interest incurred by the new owner.

ILLUSTRATIVE EXAMPLE

Seller's original building cost was \$1,250,000 on July 1, 1980, with a useful life of 40 years. On July 1, 1992, the facility is purchased by Buyer for \$3,500,000 who decides to invest some of his own money in the purchase and finance the remainder at 9%. Accumulated depreciation for the building as of July 1, 1992 is \$375,000, and the net book value is therefore \$875,000. The portion of the selling price allocated to the building is \$1,531,250. Buyer's remaining useful life for the building is 28 years. Buyer reported depreciation for the building for FYE 6/30/93 of \$54,688. The building revaluation and depreciation limit is computed below. The index for assets acquired in 1980 and sold in 1992 is 1.17.

Seller's original building cost in 1980	\$1,250,000
Cost multiplier	1.17
Revalued original cost	\$1,462,500
Accumulated depreciation	(\$375,000)
Allowable basis to buyer	\$1,087,500
Allowable depreciation (\$1,087,500/28)	\$38,839
Reported depreciation	\$54,688
Non-allowable depreciation	\$15,849

Assuming the provider's allowable basis for all assets (including the building and equipment) is \$2,292,322, allowable return on equity and interest would be computed as follows:

- (i) If the buyer, (a for-profit entity), pays \$1,000,000 down and finances the remaining \$2,500,000 of the purchase, then he is allowed return on equity on \$1,000,000 and interest expense of \$1,292,322 at 9% for the loan term. Allowable interest expense decreases each year as principal is repaid.
- (ii) If the buyer (a for-profit entity) pays \$2,500,000 down and finances the remaining \$1,000,000 of the purchase, then he is allowed return on equity of \$2,292,322 and NO interest expense.
- (iii) If the buyer (a not-for-profit entity) pays \$1,000,000 down and finances the remaining \$2,500,000 of the purchase, then he is allowed NO return on equity, and is allowed interest expense of \$1,292,322 at 9% for the loan term. Allowable interest expense decreases each year as principal is repaid.
- (i) A return on equity of no more than the amount allowed under Medicare principles in effect for services prior to October 1, 1993, shall be included as an allowable cost for proprietary providers, limited to \$1.50 per patient day, and by the maximum payment rate.
- (j) The effect of minimum wage and other direct pass-through cost items will be eliminated in the application of the inflation allowance.

(Rule 1200-13-6-.10, continued)

- (k) An incentive payment will be included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80% or greater. Certain expenses are fixed and not controllable on a day today basis. These expenses include allowable rent, property taxes and insurance, depreciation, and interest. Total costs are determined for each provider and converted to a per patient day basis. Fixed costs are also determined for each provider and converted to a per patient day basis. Variable costs are determined by subtracting the fixed costs from the total costs. All intermediate care providers whose variable costs are less than the maximum reimbursement rate shall be eligible to receive a fifty percent (50%) cost containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars (\$3) per patient day and by the maximum reimbursement rate.
- (l) No carryover of allowable costs shall be allowed.
- (m) Providers of ICF/MR Services
 - 1. For providers of ICF/MR services, the total of management fees charged by a non-related management company plus the total of home office costs claimed by a related parent company, is limited to the lesser of:
 - (i) Allowable costs of the non-related management company and the related parent company.
 - (ii) Charges, or
 - (iii) 45% of total allowable administrative costs of the provider.
 - (iv) In addition, management fees of a non-related management company is further limited by:
 - I. The amount specified in the management contract between the management company and the ICF/MR facility; and
 - II. The maximum component fees as defined in (h) below.
 - 2. A non-related management company is an independent entity not related to the provider by ownership or control and which obtains its contract with the provider by means of an arms-length transaction. If a management company does not obtain its contract by means of an arms-length transaction, it will be deemed a related parent company. The management fees of a non-related management company are not allowable unless the company manages at least two ICF/MR facilities. A related parent company is one which owns, in part or in whole, its subsidiary ICF/MR facilities, or exercises significant control over its subsidiary ICF/MR facilities. A related parent company, as well as a non-related management company, maintains offices and administrative staff separate from and in addition to the individual facilities' administrative offices and administrative staff.
 - 3. For purposes of this rule, the term ownership is as defined to rule 1200-13-6-.09E.9. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

(Rule 1200-13-6-.10, continued)

4. The allowable costs of a non-related management company may include a profit factor equal to the return on equity percentage currently allowed under the program. Unless otherwise indicated by state rules, allowable costs are determined in accordance with Medicare principles of retrospective reimbursement. Interest paid on overdue management fees is considered part of the management fees in the year paid.
5. For purposes of this provision, charges is the amount claimed for reimbursement by a non-related management company or related parent company on provider cost reports submitted to the state.
6. For purposes of this rule, administrative and general costs of the provider include the following:
 - (i) Salary of administrator;
 - (ii) Other administrative salaries;
 - (iii) Office supplies and printing;
 - (iv) Communications (telephone, fax);
 - (v) Travel expenses;
 - (vi) Advertising and public relations;
 - (vii) Licenses, dues and subscriptions;
 - (vii) Professional training and education;
 - (ix) Conference registration and fees;
 - (x) Accounting, bookkeeping, and auditing expenses;
 - (xi) Legal services;
 - (xii) Pharmacy, nursing, dietary, and all other consulting services;
 - (xiii) Franchise and filing fees;
 - (xiv) Excise taxes;
 - (xv) Insurance (other than property insurance);
 - (xvi) Utilization review expenses;
 - (xvii) Management fees; and
 - (xviii) Home office costs.
7. The provider services tax is not included in administrative and general costs of the provider.
8. For purposes of this rule, maximum component fees are upper limits for services documented as provided by non-related management companies to client ICF/MR facilities. Component fees are allowable only if the service is not provided by the ICF/MR with its own staff or by independent contractors separate from the management company. Management companies and/or ICF/MR must maintain documentation that the service(s) are actually provided on-site at the ICF/MR facilities. Accounting and bookkeeping services do not necessarily have to be performed onsite at the provider. The annual maximum component limits are as follows for facilities greater than 50 beds:

Nurse Consultant Services	\$10,500
Human Resource Services	\$10,500
Crisis Intervention Services	\$10,500
Pharmacy Consultant Services	\$7,000
Dietary Consultant Services	\$7,000
Social Service Consultant Services	\$3,000
Activity Service Consulting	\$1,500
Medical Records Consulting	\$1,500
Accounting Services	\$50,000
Bookkeeping Services	\$20,000

(Rule 1200-13-6-.10, continued)

Staff Training Services	\$10,000
Retainer for Legal Counsel	\$3,000
General Oversight and Supervision	<u>\$50,000</u>
Total	<u>\$184,500</u>

9. The maximum annual allowable management fee for component services under this subsection, before consideration of allowances for management company profit and overhead, is \$184,500. An additional 20% of the total allowed components will be added for overhead. In addition, a profit margin based on the total allowed components will be added. The profit percentage will be the current return on equity percentage used under the program. For facilities 50 beds or less, applicable amounts will be one-half the above amounts.

Illustrative Example

Assume the following: A non-related management company is limited to (a)4.(ii), maximum component fees. The management company manages five nursing facilities for the entire year. Four of the facilities have 100 beds and the fifth has 45 beds. Assume the applicable return on equity percentage is 7%. The management company documents that it has provided the following services to each of the five providers:

- (i) Nurse Consulting
- (ii) Human Resource Services
- (ii) Crisis Intervention Services
- (iv) Accounting
- (v) Staff Training
- (vi) General Oversight and Supervision

The maximum allowable management fee for each of the 100 bed facilities is \$179,705 computed as follows:

Nurse Consulting	\$10,500
Human Resource Services	\$10,500
Crisis Intervention Services	\$10,500
Accounting	\$50,000
Staff Training	\$10,000
General Oversight/Supervision	<u>\$50,000</u>
Subtotal	\$141,500
Add overhead (20%)	28,300
Add profit (7%)	9,905
Total Allowable	<u>\$179,705</u>

The maximum allowable management fee for the 45 bed facility is \$89,853.

10. It is the responsibility of ICF/MR providers to submit cost information of non-related management companies. Initially, the cost information is to be submitted on the effective date of this rule. Subsequently, the cost of non-related management companies shall include, but not be limited to, audited financial statements, a detailed trial balance, and allocation of costs to all managed facilities and owned facilities, if any, as well to other business activities of the management company. The cost information is subject to audit by the state Comptroller's Office. In the event that audited financial statements are

(Rule 1200-13-6-.10, continued)

not available, unaudited statements shall be submitted. In the event that the fiscal year end of the management company differs from the fiscal year end of the ICF/MR provider(s), information from the most recently completed fiscal year shall be submitted. Cost reports submitted without the required management company cost information shall be considered incomplete and will not be processed. Providers will be subject to a penalty of \$10 per day in accordance with state law until the required cost information is filed.

11. The provisions of this section do not apply to ICF/MR services covered under a capitated payment system nor to management contracts with annual fees less than \$75,000.

(2) Workers Compensation Expenses

For Medicaid cost reporting purposes, when additional costs for workers compensation premiums are incurred from an insurance audit subsequent to a nursing facility's fiscal year end and the cost report has been filed with the Comptroller's Office without including the costs, the costs will be considered an expense in the year the amount becomes known. Should a workers compensation audit result in a premium credit, the credit will be applied to the next premium payment. In either case, amended cost reports cannot be filed.

(3) Disclosure of Information

The Tennessee Medical Assistance program will follow federal requirements pertaining to the disclosure of certain information about ownership interest, business transactions, convictions of program related criminal offenses, etc. as required by 42 CFR Chapter IV, Part 420, Subpart C, and Part 455, Subpart B, Principle C effective October 1, 1983.

(4) Patient Accounts and Patient Funds

Gross charges to the patients' accounts must match the charges to the patient log. Adjustments to the patients' accounts must then be made to bring the actual charges in line with the contractual and legal collection limits of the various medical programs. All charges in the patients' accounts must be supported by charge slips and the proper notes in the patients' files and must correspond to the charges reported on the Department billing forms. Personal funds held by the provider for Medicaid patients used in purchasing clothing and personal incidentals must be properly accounted for with detailed records of amounts received and disbursed and shall not be commingled with nursing facility funds. Patient funds in excess of \$50 per patient must be kept in an insured interest bearing account. Interest earned must be credited to the patients.

(5) Patient Logs and Census

Each facility must maintain daily census records and an adequate patient log. The format of the log is to be determined by each individual provider and may be combined with the revenue journal or other records at the convenience of the provider. This log, however, must be sufficient to provide the following information on an individual basis and to accumulate monthly and yearly totals for Medicaid NF-1 patients and for all other patients.

- (a) Days of service,
- (b) Charges for items and services covered by the Medicaid NF-1 Program,
- (c) Charges for items and services not covered by Medicaid NF-1 Program,

(Rule 1200-13-6-.10, continued)

- (d) Patient income applicable to the cost of covered items and services received by Medicaid NF-1 patients,
 - (e) Amounts collected and receivable from the Medicaid NF-1 Program, and
 - (f) Amounts collected and receivable from all other sources.
- (6) Patient Log Directions
- (a) Suggested Patient Log

The headings below should be listed across the top of the page above the respective columns.

<u>Column No.</u>	<u>Heading</u>
1	Patient Name
2	Patient Days
3	Room and Board Charge
4	Total Other NF-1 Covered Charges
5	Total NF-1 Covered Charges (Col. 3 + Col. 4)
6	Total NF-1 Noncovered Charges
7	Total Actual Charges (Col. 5 + Col. 6)
8	Date Medicaid NF-1 Claim Paid
9	Amounts Collected and Receivable from NF-1 Program
10	Patient Income Applicable to NF-1 Covered Services
11	Amounts Collected and Receivable from Patients from NF-1 Noncovered Services
12	Amounts Collected and Receivable from Other Sources
13	Total Amounts Collected and Receivable
14	Comments

- (b) Directions for Completion of the Sample Patient Log

The log should be maintained on a monthly basis with separate pages used for each month. Medicaid NF-1 patients should be listed in a separate section of the log so that Medicaid NF-1 program statistics can be generated. The columns should be completed and totaled as soon after the end of the month as the figures are available. Adjustments should be made to the monthly totals to reflect adjustments in the log due to changes in patient status, additional information, or other reasons. Complete explanations should accompany each adjustment. For non-program patients, columns 8 through 14 can be omitted or adapted for other uses.

Column 1. Patient Name--Enter the individual patient's name.

Column 2. Patient Days--Enter the patient days that the patient was charged for as this category of patient.

Column 3. Room and Board Charge--Enter the actual room and board charge, according to the facility's charge schedule, for the month.

Column 4. Total Other NF-1-Covered Charges--Enter the total of the charges other than room and board, according to the facility's charge schedule, for services covered by the NF-1 program.

Column 5. Total NF-1 Covered Charges--Enter the sum of column 3 and 4.

(Rule 1200-13-6-.10, continued)

- Column 6. Total NF-1 Noncovered Charges--Enter the total of the charges, according to the facility's charge schedule, for services not covered by the NF-1 program.
- Column 7. Total Actual Charges--Enter the sum of column 5 and column 6.
- Column 8. Date Medicaid NF-1 Claim Paid--For each Medicaid NF-1 patient, enter the date that each claim was paid by the Department of Health. For other types of patients, leave blank or adapt for other use.
- Column 9. Amounts Collected and Receivable From NF-1 Program--For each Medicaid NF-1 patient, enter the amount paid by and receivable from the Department of Health. For other types of patients, leave blank or adapt for other use.
- Column 10. Patient Income Applicable to NF-1 Covered Services--For each Medicaid NF-1 patient, enter the amount of each patient's income applicable to NF-1 services. For other types of patients, leave blank, or adapt for other use.
- Column 11. Amounts Collected and Receivable from Patients for NF-1 Noncovered Services--For each Medicaid NF-1 patient, enter the amounts collected and receivable for services not covered by the NF-1 program. For other types of patients, leave blank, or adapt for other use.
- Column 12. Amounts Collected and Receivable from Other Sources For each Medicaid NF-1 patient, enter the amounts collected from other sources. State the source under Column 14. For other types of patients, leave blank, or adapt for other use.
- Column 13. Total Amounts Collected and Due--For each Medicaid NF-1 patient, enter the sum of columns 9, 10, 11, and 12. For other types of patients, leave blank, or adapt for other use.
- Column 14. Comments--This column is for special notes relating to the entries in the log.

(7) Sample Entries to Patient Accounts, NF1 Turnaround Document, and the Patient Log.

Basic Data

	Example	Example	Example
Month-September 30 days	30	30	30
Comptroller's Office Rate Per Day	66.09	66.09	66.09
Charge Schedule:			
Room and Board Rate Per Day	60.00	70.00	66.09
NF-1 Covered Items Per Month	45.00	-----	30.00
NF-1 Noncovered Items Per Month	20.00	40.00	10.00
Patient Income Per Month (Form 2362)	482.70	482.70	482.70
Allowance Per Month	30.00	30.00	30.00

Example 1 - Basic charge is for Room and Board only for private paying patients, all other supplies and services are charged as used.

(a) Patient Account Entries

(Rule 1200-13-6-.10, continued)

<u>Date</u>	<u>Debit</u>	<u>Credit</u>	<u>Other Account</u>	<u>Nature of Charge or Credit</u>
9/1	1,800.00		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge (\$60.00 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	45.00		Revenue-Medicaid NF-1 Covered Services	NF-1 Covered Items for September
9/30	20.00		Revenue-Medicaid NF-1 Non-covered Services	NF-1 Noncovered Items for September
9/30		20.00	Cash	Collection for NF-1 Patient Personal Needs Funds
9/30		45.00	Contractual Adjustment	To adjust charge for covered services to contractual limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	<u>\$1,865.00</u>	<u>\$2,047.70</u>		

*Patient account balance applicable to September is \$182.70 overcollected

$\$66.09 \times 30 = \$1,982.70$

(b) NF-1 TURNAROUND DOCUMENT

Number of Days of Service	30
Rate Assigned by the Comptroller of the Treasury	\$66.09
$\$66.09 \times 30 \text{ days} =$	\$1,982.70
Less 2362 Amount	482.70
	<u>\$1,500.00</u>

(c) Patient Log (See Example 1)

*An adjustment must be filed with the State of Tennessee.

Example 2 Basic charge is an all inclusive rate for all patients. No extra charges to any patients for routine covered service items are made. Non-covered services are charged to all patients.

(d) Patient Account Entries

(Rule 1200-13-6-.10, continued)

<u>Date</u>	<u>Debit</u>	<u>Credit</u>	<u>Other Account</u>	<u>Nature of Charge or Credit</u>
9/1	2,100.00		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge (70.00 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	40.00		Revenue-Medicaid NF-1 Noncovered Services	NF-1 Non-Covered Items for September
9/30		30.00	Cash	Collection for NF-1 Noncovered Items from Patient Personal Needs Funds
9/30		117.30	Contractual Adjustment	To adjust charge for Covered Services to Contractual Limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	<u>\$2,140.00</u>	<u>\$2,130.00</u>		

Patient account balance applicable to September is \$10.00. This balance is solely due to charges for noncovered services. This amount can be collected from personal funds if such funds are or become available.

(e) NF-1 TURNAROUND DOCUMENT

Number of Days of Service	30
Rate Assigned by the Comptroller of the Treasury	\$66.09
$\$66.09 \times 30 \text{ days} = \$1,982.70$	
Less 2362 Amount	482.70
	<u>\$1,500.00</u>

(f) Patient Log (See Example 2)

*An adjustment must be filed with the State of Tennessee.

Example 3 -Basic charge is for Room and Board only for private paying patients, all other supplies and services are charged as used.

(g) Patient Account Entries

(Rule 1200-13-6-.10, continued)

<u>Date</u>	<u>Debit</u>	<u>Credit</u>	<u>Other Account</u>	<u>Nature of Charges or Credit</u>
9/1	1,982.70		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge (66.09 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	30.00		Revenue-Medicaid NF-1 Covered Services	NF-1 Covered Items for September
9/30	10.00		Revenue-Medicaid NF-1 Noncovered Services	NF-1 Noncovered Items for September
9/30		10.00	Cash	Collection for NF-1 Noncovered Items from Patient Personal Needs Funds
9/30		30.00	Contractual Adjustment	To Adjust Charge for Covered Services to Contractual Limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	<u>\$2,022.70</u>	<u>\$2,022.70</u>		

Patient account balance applicable to September is zero.

(h) NF-1 TURNAROUND DOCUMENT

Number of Days of Service	30
Rate Assigned by the Comptroller of the Treasury	\$66.09
$\$66.09 \times 30 \text{ days} = \$1,982.70$	
Less 2362 Amount	482.70
	<u>\$1,500.00</u>

(i) Patient Log (See Example 3)

(Rule 1200-13-6-.10, continued)

PATIENT NAME (1)	PATIENT DAYS (2)	ROOM AND BOARD CHARGE (3)	TOTAL OTHER NF1 COVERED CHARGES (4)	TOTAL NF1 COVERED CHARGES (5)	TOTAL NF1 NONCOVERED CHARGES (6)	TOTAL ACTUAL CHARGE (7)	DATE MEDICAID NF1 CLAIM PAID (8)
EXAMPLE 1	30	\$1,800.00	\$45.00	\$1,845.00	\$20.00	\$1,865.00	10/31
EXAMPLE 2	30	\$2,100.00	\$0.00	\$2,100.00	\$40.00	\$2,140.00	10/31
EXAMPLE 3	30	\$1,982.70	\$30.00	\$2,012.70	\$10.00	\$2,022.70	10/31

	AMOUNTS COLLECTED FROM NF1 PROGRAM (9)	PATIENT INCOME APPLICABLE TO NF1 COVERED SERVICES (10)	AMOUNTS COLLECTED FROM PATIENTS FOR NF1 NONCOVERED SERVICES (11)	AMOUNTS COLLECTED FROM OTHER SOURCES (12)	TOTAL AMOUNTS COLLECTED (13)	COMMENTS (14)
EXAMPLE 1 (continued)	\$1,500.00	\$482.70	\$20.00	\$0.00	\$2,002.70	\$182.70 OVERPAYMENT TO BE REFUNDED TO NF1 PROGRAM. \$45.00 CONTRACTUAL ADJUSTMENT.
EXAMPLE 2 (continued)	\$1,500.00	\$482.70	\$30.00	\$0.00	\$2,012.70	\$117.30 CONTRACTUAL ADJUSTMENT.
EXAMPLE 3	\$1,500.00	\$482.70	\$10.00	\$0.00	\$1,992.70	\$30.00 CONTRACTUAL ADJUSTMENT.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order 23. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed September 14, 1992; effective October 29, 1992. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed May 18, 2000; effective August 2, 2000.

1200-13-6.11 NURSING FACILITY ALLOWABLE COMPENSATION RANGES.**(1) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED IN AN INDIVIDUAL NURSING FACILITY.****(a) Administrator:**

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
25 or under	\$20,230	\$--		\$10,230
26 - 50	20,621	390.34	26 beds	29,989
51 - 75	30,352	362.25	51 beds	39,046
76 - 100	39,213	169.75	76 beds	43,287
101 - 150	43,368	79.22	101 beds	47,250
151 & above	47,329	79.22	151 beds	59,274

(b) Other Positions:

	1-50 Beds	51-100 Beds	101-150 Beds	151 & Above Beds
Assistant or Co-Administrator	\$--	\$26,171	\$27,020	\$28,153
Bookkeeper I	7,401	20,230	22,351	24,474
Licensed Dietitian	23,767	24,616	25,323	26,738
Dietary Supervisor	15,702	17,684	19,522	21,502
Dietary Worker	14,429	14,429	14,429	14,429
Housekeeping Supervisor	14,855	16,552	17,964	19,664
Housekeeper	14,429	14,429	14,429	14,429
Laundry Supervisor	--	--	17,401	17,964
Laundry & Linen Worker	14,429	14,429	14,429	14,429
Maintenance Man	19,664	19,664	19,664	19,664
Medical Director	33,387	33,387	33,387	33,387
Director of Nursing	27,160	28,292	29,989	33,387
Registered Nurse	25,039	25,888	26,738	28,009
Licensed Practical Nurse	19,380	20,230	20,795	21,502
Speech, Occupational, Physical, Recreational Therapist	26,738	26,738	26,738	26,738
Attendants, Orderlies, Aides	15,702	15,702	15,702	15,702
Recreational Director	15,702	15,702	15,702	15,702
Activity Coordinator				
Social Activities Director	16,409	16,409	16,409	16,409
Medical Records Clerk	17,684	18,391	19,098	19,664
Secretary	20,514	20,514	20,514	20,514

(c) The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent. For purposes of this rule, a normal work week is defined as 40 hours.

(d) If the facility has under 51 beds, only (1) Administrator and/or Business Manager is allowed, and the rate is set according to bed size/Administrator table.

(e) Allowances for any position not specifically listed herein will be based on other comparable positions and other available information.

(Rule 1200-13-6-.11, continued)

- (f) Allowances for any position shall not exceed the administrator's compensation.
- (g) Other items of consideration to be used in adjustments to these maximum allowances are:
 - 1. necessity of services provided and duties performed by the individual,
 - 2. the time period during which these duties were performed,
 - 3. accounting period bed changes based on dates of change,
 - 4. other relevant circumstances and data verified by the Comptroller of the Treasury.
- (h) Allowable compensation amounts shown above will be increased annually effective with cost reports ending June 30 and later based on the preliminary Skilled Nursing Facility Market Basket Index as computed by Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimate, current as of June 30, but in no case will the annual compensation adjustment exceed 10%.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, Executive Order No. 1 of 1995, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 15, 1996; effective September 28, 1996.

1200-13-6-.12 ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES WHOSE SUBSIDIARY OR DIVISION PARTICIPATES IN THE BUREAU OF TENNCARE NURSING FACILITY LEVEL I PROGRAM.

(1) Chief Operating Executive:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
200 and under	\$27,729	\$--	--	\$27,729
201 - 500	27,746	19.81	201 beds	33,668
501 - 1,000	33,686	18.68	501 beds	43,005
1001 - 2,000	43,023	18.25	1,001 beds	61,254
2,001 and over	61,271	17.24	2,001 beds	160,421

Allowance as %

of Chief Operating
Executive Compensation Maximum

(2) Other Positions:

Medical Director (M.D.)	90%	N/A
Assistant Chief Operating Executive, Controller, Corporate Secretary, Treasurer, Attorney	75%	N/A
Accountant, Business Manager, Purchasing Agent, Regional Administrator, Regional VicePresident, Regional Executive Consultants, (Social Activities, Dietary, (R.D.), Physical Therapist (RPT), Medical Records (RRA),	70%	\$36,356

(Rule 1200-13-6-.12, continued)

Nursing (B.S.R.N.))	65%	29,143
Secretaries/Clerks	25,514	
Bookkeepers		24,474

- (3) The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. For purposes of this rule, a normal work week is defined as 40 hours.
- (4) No assistant operating executive will be authorized for a chain with 200 beds or less.
- (5) If chief operating executive is a licensed administrator and is actually performing the duties of administrator in one of the facilities, those owner/administrator guidelines will apply.
- (6) Other items of consideration to be used in adjustments to these maximum allowances:
 - (a) services provided to the facilities by home office,
 - (b) positions filled and duties performed by other personnel in the home office compared to related positions and duties performed by other personnel in the individual facilities,
 - (c) comparable salaries that would have to be paid to non-owners for the same services,
 - (d) accounting period bed changes based on dates of change, and
 - (e) other relevant circumstances and data verified by the Comptroller of the Treasury.
- (7) Allowable compensation amounts will be increased annually using the same percentage that is developed under 1200-13-6-.11(8).

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989.

1200-13-6-.13 ESTABLISHMENT OF PER DIEM REIMBURSEMENT RATES.

- (1) The Comptroller of the Treasury will establish per diem reimbursement rates for nursing facility Level I services provided to Tennessee Medicaid recipients.
- (2) The Comptroller of the Treasury will use:
 - (a) the cost report required by rule 0380-1-10-.07,
 - (b) budgeted information supplied by the provider,
 - (c) the charge system of the provider, and
 - (d) any other data the Comptroller considers relevant in rate determination.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6-.14 MAXIMUM AMOUNT OF REIMBURSABLE COST PAYABLE TO A PROVIDER.

- (1) The maximum amount of reimbursable cost payable to a provider as provided for in these rules and regulations shall be the lesser of:
 - (a) The usual and customary charges for comparable services of a particular provider; or

(Rule 1200-13-6-.14, continued)

- (b) A maximum program-wide rate for Nursing facility Level I services as may be established by the Department in consultation with the Department of Finance and Administration; or
- (c) An allowable amount as determined by the Comptroller of the Treasury in accordance with the Department's rules. In the event that an item is not addressed in the Department's rules, Medicare principles of retrospective cost reimbursement shall apply.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.

1200-13-6-.15 AUDITING OF COST REPORTS. The cost reports filed in accordance with the rules above and all provider records pertaining thereto shall be subject to audit by the Comptroller of the Treasury or his agents. The cost reports filed in accordance with the rules above must provide adequate cost and statistical data. This data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate and in sufficient detail to support payment made for services rendered to beneficiaries. This data must also be available for and capable of verification by the Comptroller of the Treasury or his agents. The provider must permit the Comptroller or his agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data reflected on the cost report which cannot be substantiated may be disallowed with reimbursement being required of the provider.

Authority: T.C.A. §§14-23-105, 14-23-109, 14-23-130, and 4-5-202. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988.

1200-13-6-.16 RECORDS RETENTION. Each provider of Level I nursing facility services is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health, the State Comptroller of the Treasury, or the United States Department of Health and Human Services.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.