RULES
OF
TENNESSEE DERPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF MEDICAID

CHAPTER 1200-13-8
SKILLED NURSING HOME PROGRAM

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1200-13-8-.01 DETERMINATION OF REIMBURSABLE COST FOR SKILLED NURSING CARE. 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 those institutions or distinct parts thereof providing skilled nursing care. The Department may establish the maximum amount to be paid to such institutions.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.02 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those institutions or distinct parts thereof designated and certified by, and contracting with, the Department as rendering skilled nursing care 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. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.03 COVERED SERVICES. The specific items and services covered under skilled nursing care shall be those defined and approved by the Department. Noncovered services may be charged directly to the recipient.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.04 BILLING PROCEDURE. Institutions or distinct parts thereof rendering skilled nursing care shall bill the Department on the forms and in the manner designated by the Department.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.05 CHARGES TO SKILLED NURSING FACILITY RECIPIENTS. The charge schedule of a provider must be applied uniformly to all patients as services are furnished. Appropriate writeoffs or adjustments shall be made to each Medicaid recipient's account to reduce the gross charges to the contractual or legal collection limits of the Medicaid Program.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.06 EXTENT OF REIMBURSEMENT. The per diem reimbursable costs of institutions or distinct parts thereof rendering skilled nursing care shall be reimbursable by the State as provided in Rule 1200-13-8-.14 with the remainder not allowable as outside support from other sources. The provider shall be limited to reimbursable per diem as the maximum it may collect from all sources for program services.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.07 ESTABLISHMENT OF PROSPECTIVE PER DIEM COST RATES. The Comptroller of the Treasury will establish prospective per diem reimbursement rates for the institutions or distinct parts thereof rendering Level II nursing care (formerly referred to as skilled nursing care). The Comptroller of the Treasury shall consider the charge system of the provider, prior cost date, results of audits, budgeted information supplied by the provider in instances of new facilities, and any other relevant data submitted by the provider in establishing these rates.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Amendment filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.08 SUBMISSION OF COST REPORTS BY PROVIDERS.

(1) In-state and out-of-state Providers of Medicaid Level II nursing care will be required to contract with the Department and submit to the Comptroller of the Treasury a pro-forma (budgeted) cost report upon beginning participation as a new provider. 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 on forms designated by the Department. The report shall be due within three (3) months after the end of the designated fiscal period or the alternative due date designated by Medicare if applicable. 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. All covered charges are to be in accordance with the Medicaid Program definition of covered services. Also, all charges to Medicaid recipients must be made consistently and in accordance with the providers schedule of charges in effect for the period covered for all patients. In the event that a 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 T.C.A. 12-4-304. 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.

(2) Providers of skilled nursing care that do not file cost reports required in this section or do not file the cost reports in a timely manner as provided in Medicare Principles of Reimbursement, in effect October 1, 1984, may be subject to sanctions as provided by the Medicare Principles of Reimbursement. Providers of skilled nursing care who fail to file cost reports for a specific period shall be subject to penalties in accordance with state law.

(3) After a period of five years following the implementation of Medicaid prospective payment for Level II nursing facility services on October 1, 1996, amended or corrected Level II nursing facility cost reports with claims for reimbursement for services prior to October 1, 1996 shall not be accepted.

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 March 7, 1989; effective April 21, 1989. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed July 25, 2002; effective October 8, 2002.*

1200-13-8-.09 MAXIMUM COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES. Effective for fiscal years ending June 30, 1984 and later, the following maximum compensation for owners and/or their relatives employed by an individual skilled care facility or by a parent company whose subsidiary or division participates in the Medicaid Skilled Care Program shall apply.

(1) MAXIMUM COMPENSATION FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED IN AN INDIVIDUAL SKILLED NURSING FACILITY.

(a) Administrator:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
25 or under	$15,824	$--		$15,824
26 - 50	16,129	305.33	26 beds	23,457
51 - 75	23,741	283.29	51 beds	30,540
76 - 100	30,672	132.75	76 beds	33,858
101 - 150	33,922	61.96	101 beds	36,958
151 & above	37,019	61.96	151 beds	46,363

(b) Other Positions:

	1 - 50 Beds	51- 100 Beds	101- 150 Beds	151 & Above Beds
Assistant or Co-Administrator	$----	$20,471	$21,135	$22,020
Bookkeeper	13,611	15,824	17,483	19,143
Licensed Dietician	18,590	19,254	19,807	20,913
Dietary Supervisor	12,282	13,832	15,270	16,818
Dietary Worker	11,286	11,286	11,286	11,286
Housekeeping Supervisor	11,618	12,946	14,052	15,381
Housekeeper	11,286	11,286	11,286	11,286
Laundry Supervisor	---	---	13,611	14,052
Laundry & Linen Worker	11,286	11,286	11,286	11,286
Maintenance Man	15,381	15,381	15,381	15,381
Medical Director	26,114	26,114	26,114	26,114
Director of Nursing	21,244	22,130	23,457	26,114
Registered Nurse	19,585	20,249	20,913	21,909
Licensed Practical Nurse	15,159	15,824	16,265	16,818
Speech, Occupational, Physical, Recreational Therapist	20,913	20,913	20,913	20,913
Attendants, Orderlies, Aides	12,282	12,282	12,282	12,282
Recreational Director Activity Coordinator Social Activities Director	12,835	12,835	12,835	12,835
Medical Records Clerk	13,832	14,385	14,938	15,381
Secretary	16,045	16,045	16,045	16,045

(Rule 1200-13-8-.09, continued)

(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.

(d) If the facility has under 51 beds, only one (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.

(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 adjusted 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%.

(2) MAXIMUM COMPENSATION FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES WHOSE SUBSIDIARY OR DIVISION PARTICIPATES IN THE MEDICAID SKILLED NURSING PROGRAM

(a) Chief Operating Executive:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
200 & Under	$21,688	$---	---	$21,688
201 500	21,703	15.49	201 beds	26,335
501 1,000	26,349	14.61	501 beds	33,638
1,001 2,000	33,652	14.27	1,001 beds	47,912
2,001 & over	47,925	13.49	2,001 beds	125,479

(b) Other Positions

	Allowance as % of Chief Operating Executive Compensation	Maximum
Medical Director (M.D.)	90%	
Assistant Chief Operating Executive, Controller, Corporate Secretary, Treasurer, Attorney	75%	

(Rule 1200-13-8-.09, continued)

	Allowance as % of Chief Operating Executive Compensation	Maximum
Accountant, Business Manager, Purchasing Agent, Regional Administrator, Regional ice President, Regional Executive	70%	$28,437
Consultants, (Social Activities, Dietary (R.D.), Physical Therapist (RPT), Medical Records (RRA), Nursing (B.S.R.N.)	65%	22,794
Secretaries/Clerks		16,045
Bookkeepers		19,143

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.

(c) No assistant operating executive will be authorized for a chain with 200 beds or less.

(d) 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.

(e) Other items of consideration to be used in adjustments to these maximum allowances:

1. services provided to the facilities by home office,

2. 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,

3. comparable salaries that would have to be paid to nonowners for the same services,

4. accounting period bed changes based on dates of change, and

5. Other relevant circumstances and data verified by the Comptroller of the Treasury.

(f) Allowable compensation amounts will be adjusted annually using the same percentage that is developed under rule 1200-13-8-.09(1)(h).

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.10 EXPENSES RELATED TO DISALLOWED CAPITAL EXPENDITURES. 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 occurring on or after June 24, 1973, and on or before August 31, 1979, and that exceeds $100,000, or on or after September 1, 1979, and on or before July 17, 1984, that exceeds $150,000, and on or after July 18, 1984, and on or before April 17, 1985, that exceeds $500,000, and on or after April 18, 1985, and on or before June 30, 1987 that

(Rule 1200-13-8-.10, continued)

exceeds $1,000,000, and on or after July 1, 1987, that exceeds $1,500,000, or change the facility bed capacity, or substantially change the facility's services, and that have not been approved by the Tennessee Health Facilities Commission and or its successor agency.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.11 LEASE AND RENT EXPENSE. On a new lease negotiated after December 31, 1977, and renewal of such lease, 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, (for approved capital expenditures excluding expenses not considered allowable) in accordance with Rule 1200-138-.10, will be considered an allowable cost. Renewal of a lease negotiated before January 1, 1978, 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.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.12 CHANGE OF OWNERSHIP.

Additional capital costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities under going a change of ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1984. The cost basis of depreciable assets in a sale not considered bona fide is additionally limited to (5) the seller's cost basis less accumulated depreciation. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.13 RESERVED.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Repeal filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.14 INCENTIVE PAYMENT. An incentive payment will be included in the reimbursable costs of Level II providers that sufficiently contain costs and maintain an average occupancy rate of 80% or greater. Skilled providers with operating costs less than the maximum reimbursable 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 per patient day and by the maximum reimbursement rate. Operating costs are defined as total costs less capital-related costs.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.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 Department, the Comptroller of the Treasury, or their agents. The cost reports filed in accordance with the rules above must provide adequate cost and statistical

(Rule 1200-13-8-.15, continued)

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 Department, the Comptroller of the Treasury, or their agents. The provider must permit the Department, the Comptroller or their agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data as reflected on the cost report which cannot be substantiated shall be disallowed with reimbursement being required of the provider. The Department will provide for all costs of auditing performed under this provision. However, the costs of audits or other costs incurred in the preparation of cost reports are not covered by this provision.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.16 RECORDS RETENTION. Each provider of skilled nursing 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 immediately make such records available upon demand to representatives of the Department, the State Comptroller of the Treasury, or the United States Department of Health and Human Services, or their agents.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*