FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION XLI EFFECTIVE: July 1, 2013

I. Cost Finding and Cost Reporting

A. Each provider participating in the Florida Medicaid nursing home program shall submit a uniform cost report and related documents required by this plan. The electronic cost report and revised instructions must be used. To be considered a complete submission, the electronic version of the cost report, one hard copy of the cost report, the certification page, supplemental schedules and attachments, and the accountant's compilation letter must all be received by the Agency for Healthcare Administration (the Agency), Bureau of Medicaid Program Analysis, Audit Services. Cost reports are due to the Agency, Bureau of Medicaid Program Analysis, Audit Services five months after the close of the provider's cost reporting year. Extensions will not be granted.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. For a new provider with no cost history in a newly constructed facility, an existing provider entering the program, an existing provider in a newly constructed replacement facility, or a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Medicaid program, the interim operating, direct care, and indirect care cost per diems shall be the lesser of: the effective class reimbursement ceiling based on Section V.B.13. of this plan, the budgeted operating, direct care, and indirect care cost per diems approved by the Agency based on Section III. of this plan, or the new provider target limitation. The new provider target limitation for a new provider with no cost history in a newly constructed facility or an existing provider entering the program shall be the average operating and indirect care per diems (excluding Medicaid Adjustment Rate, hereinafter referenced as M.A.R.) in the area in which the facility is located plus 50 percent of the difference between the average area per diem (excluding M.A.R.) and the facility's effective class ceiling. The new provider target limitation for existing

providers in a newly constructed replacement facility shall be the greater of the above new provider target limitation or their current operating and indirect care cost per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility's effective class ceilings. The average area per diem is calculated by taking the sum of all operating, direct care, and indirect care per diems within the area divided by the number of facilities within the area. The new provider target limitation for a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Medicaid program shall be the previous provider's operating and indirect care cost per diem (excluding M.A.R.), plus 50 percent of the difference between the previous provider's per diem (excluding M.A.R.) and the effective class ceiling. The above new provider target limitation, whether based on the area average per diem or the previous provider's per diem, shall apply to all new providers with a Medicaid certification. The new provider target limitation above, whether based on the area average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate semester in which the target reimbursement provision in Section V.B.14. of this plan does not apply. The new provider target limitation shall apply to new providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.14. of this plan does not apply. New provider target limitations applicable to the first rate semester a new provider enters the program shall be the basis for calculating subsequent rate semester new provider target limitations for that same provider through the following calculation:

Establish the target reimbursement for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost in Step I.B. from the previous rate semester, excluding the M.A.R.with the quantity:

$$1 + 2.0 \times \frac{\text{Florida Nursing Home Cost Inflation Index (at the midpoint of the prospective rate period)}}{\text{Florida Nursing Home Cost Inflation Index (at the midpoint of the prospective rate period -1)}}$$

Florida Nursing Home Cost Inflation Index at
the midpoint of the current rate period

In the above calculation, the 2.0 shall be referred to as the provider specific inflation multiplier. The direct care component shall not be limited to the new provider target limitation described above. The new provider target limitation shall not fall below 75 percent of the cost based class ceiling for each rate setting as calculated in Section V.B.12.

For new providers who enter the program operating a facility that had been previously operated by a Medicaid provider, the property reimbursement rate shall be established per Section V.D.3.-4. of this plan. The property cost per diem for a provider with a newly constructed facility or replacement facility shall be the lesser of the budgeted fair rental value rate approved by the Agency based on Section V.D. of this plan, or the applicable fair rental value based upon the cost per bed standard that was in effect six months prior to the date the facility was first put in service as a nursing home but not prior to January 1, 1972. Return on equity or use allowance per diems shall be the budgeted rate approved by the Agencyper Section III. of this plan. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but not more than 18 months. Cost reporting periods shall be for periods of 6 months or more but not more than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations. For changes of ownership or licensed operator, the provider is required to file an initial cost report.

C. The cost report shall be prepared using the electronic cost report described in Section I.A., and on the accrual basis of accounting in accordance with Generally Accepted Accounting Principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, Florida Administrative Code. The methods of reimbursement areaccordance with Title XVIII of the Social Security Act (S.S.A.) and Center for Medicare and Medicaid Services (CMS) publication 15-1 (CMS-PUB.15-1) incorporated herein by reference except as modified by the Florida Title XIX Long Term Care Reimbursement Plan and State of

Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The CPA preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., and AICPA statements on auditing standards. Cost reports which are not signed by a certified public accountant, or not accompanied by a separate letter signed by a CPA shall not be accepted.

D. Providers may elect, with prior approval from the AgencyBureau of Medicaid Program Analysis, Audit Services, to change their current fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same fiscal year end.

E. All prior year cost reports must be submitted to and accepted by the Agency before the current year cost report may be submitted and accepted for rate setting by the Agency. If a provider submits a cost report after the due date for the cost report and after the cost report acceptance cut off date for the first rate setting after the due date for the cost report for which the cost report could have been used if the cost report had been received on the cost report due date, then that cost report shall be late tested. The late test shall consist of recalculating the per diem rates for the first rate setting after the due date for the cost report for which the cost report could have been used if the cost report had been received on the cost report due date and all subsequent rate semesters. If the new cost report sets a lower per diem rate for a rate semester as compared to the rate previously set, then the providers' rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. If the new cost report sets a higher per diem rate for a rate semester as compared to the rate previously set, then the late tested cost report shall not be used for that rate semester. If a provider

submits more than one late cost report at the same time, the cost reports shall be late tested in fiscal year end date order. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate semester had it been submitted timely, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effective retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft or wind.

F. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS-PUB.15-1, when that provider has been receiving an interim reimbursement rate. All providers are required to maintain financial and statistical records in accordance with 42 Code of Federal Regulations (CFR) 413.24, Sections (a), (b), (c), and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of costs and other records in accordance with CMS PUB. 15-1, which pertain to the determination of reasonable costs, and shall be capable of and available for auditing by state and federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of five years following the date of submission of the cost report form to the Agency.

G. Records of related organizations as identified by 42 CFR 413.17 shall be available upon demand to representatives, employees, or contractors of the Agency, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).

H. The Agency shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes (F.S).

I. Chart of Accounts: All providers must use the most recent version of the standard chart of accounts (AHCA Form Number 5300-0001 OCT 03) to govern the content and manner of the presentation of financial information to be submitted by Medicaid long-term care providers in their cost reports. The standard chart of accounts includes specific accounts for each component of direct care staff by type of personnel and may not be revised without the written consent of the Auditor General.

J. Cost reports must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

K. The Agency reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

L. Providers are subject to sanctions pursuant to Section 409.913(15)(c), F.S., and 409.913(16)(c), F.S, for late cost reports. The amount of the sanctions can be found in Rule 59G-9.070, Florida Administrative Code. A cost report is late if it is not received by the Agency, Bureau of Medicaid Program Analysis, Audit Services on the first cost report acceptance cut-off date after the cost report due date.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing home care in accordance with this plan are subject to an audit or desk review on a random basis and at any time the Agency has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. General Description of the Agency's Procedures for Audits

1. Primary responsibility for the audit of providers shall be borne by the Agency. The efforts of the Agency audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 will be met.
2. All audits shall be based on generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, Florida Administrative Code., of the AICPA.
3. Upon completion of each audit, the auditors shall issue a report that meets the requirements of 42 CFR 447.202 and generally accepted auditing standards as incorporated by reference in Rule 61H1- 20.008, Florida Administrative Code. The auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by the Agency for three years.
4. The provider's copy of the audit report shall include all audit adjustments and changes and the authority for each, and all audit findings. The audit report shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

Upon receipt of a cost report from the provider prepared in accordance with instructions furnished by the Agency, the Agency will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing by the the Agency audit office or CPA firm assigned to perform the audit or desk review.

1. Upon completion of an audit or desk review and before publication of the audit or desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least 10 days before the exit conference. If the provider fails to schedule an exit conference within 20 calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in the Agency's office in Tallahassee.

2. Following the exit conference, the provider has 60 calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. For adjustments made due to lack of adequate documentation or lack of support, any documentation received after the 60 day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the 60 day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested to the address of the nursing home to the attention of the administrator. The provider shall have 21 calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustment or finding contained in the report by requesting an administrative hearing in accordance with Section 120.57, F.S., and Chapter 28.106, Florida Administrative Code. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively demonstrate the entitlement to the Medicaid

reimbursement. Except as otherwise provided in this Plan, Chapter 28-106, Florida Administrative Code, shall be applicable to any administrative proceeding under this plan.

4. Collection of overpayments or refunds of amounts collected in error will be in accordance with Section 414.41, F.S., and Rule 59G-6.010, Florida Administrative Code.

III. Allowable Costs

A. All items of expense shall be included on the cost report, which providers must incur in meeting:

1. The definition of nursing facilities contained in Sections 1919(a), (b), (c), and (d) of the S.S.A.

2. The standards prescribed by the Secretary of HHS for nursing facilities in regulations under the S.S.A. in 42 CFR 483, Subpart B.

3. The requirements established by the Agency which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610.

B. All therapy required by 42 CFR 409.33 and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These include physical, audiology, speech pathology and occupational therapies.

C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by the Agency, utilizing the Title XVIII Principles of Reimbursement, CMS-PUB.15-1 and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

D. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items is available in the

most current version of the Nursing Facility Services Coverage and Limitations Handbook. The following are examples of expenses that allowable costs for routine services shall include:

1. All general nursing services, such as: oxygen and related medications, hand feeding, incontinency care, tray service, and enemas;
2. Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans;
3. Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-legend drugs ordinarily kept on hand, suppositories, and tongue depressors;
4. Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;
5. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician because these supplements have been classified by the Food and Drug Administration as a food rather than a drug;
6. Laundry services, including basic personal laundry services, but excluding dry cleaning, mending, hand washing or other specialty services, shall be an allowable cost.

E. Bad debts other than Title XIX of the S.S.A., charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX of the S.S.A. shall be limited to Title XIX of the S.S.A. uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily rate is $34.00; State pays $26.00 and patient is to pay $8.00. If Medicaid patient pays only $6.00, then $2.00 would be an allowable bad debt.

All Medicaid Title XIX of the S.S.A. bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters, etc.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Title XVIII of the S.S.A. and Chapter 10, CMS-PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The Owner-Administrator and Owner-Assistant Administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 or determined by surveyed ranges of compensation conducted by the Agency. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and shall be updated each year by the wage and salary component of the plan's inflation index. A new salary survey may be conducted at the discretion of the Agency.

2. Limitation of rents:

a. For the purposes of this provision, allowable ownership costs of leased property shall be defined as:

(1) Cost of depreciable assets, property taxes on personal and real property, and property insurance;

(2) Sales tax on lease payments except in cases of related parties;

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

b. Lease costs allowed for lease contracts existing as of August 31, 1984, shall remain unchanged except for increases specified in the contract entered into by the lessee and lessor before September 1, 1984. If, prior to October 1, 1985, the lessee exercises an option to renew the lease that existed as of August 31, 1984, increases in lease cost for each year of the renewal period shall be limited to the increase in the Florida Construction Cost Inflation Index (See Appendix B) during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider's reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.D.1. of this plan.

c. (1) For facilities that were not leased as of August 31, 1984 and that are operating under a lease agreement commencing on or after September 1, 1984 and before October 1, 1985, the Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the allowable ownership costs of the leased property per Section III.G.3.-5.

(2) Annual increases in lease costs for providers in (l) above shall be limited to the increase in the Florida Construction Cost Inflation Index in Appendix B during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider's reimbursement for lease costs and other property costs shall

be based on a fair rental value system (FRVS) for the facility per Section V.D.1. of this plan.

d. (1) Providers that leased facilities on or after October 1, 1985, shall be reimbursed for lease costs and other property costs based on the FRVS per Section V.D.1. of this plan. Allowable ownership costs shall be documented to the Agency for purposes of computing the fair rental value. Facilities not currently reimbursed based on the FRVS per Section V.D.1. of this plan shall not become reimbursed based on the FRVS per Section V.D.1. of this plan, solely due to the execution of a lease agreement between related organizations under Section III.F. of this plan.

(2) In no case shall Medicaid reimburse property costs of a provider who is subject to b., c., and d. (1) above and e. below, if ownership costs are not properly documented per the provisions of this plan. Providers shall not be reimbursed for property costs if proper documentation of the owner's costs, capable of being verified by an auditor, is not submitted to the Agency. The owner shall be required to sign a letter to the Agency that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing home properties available to auditors or official representatives of the Agency.

(3) Approval shall not be given for a proof of financial ability for a provider if the provider is leasing the facility and does not submit the

documentation of the owner's costs with the letter signed by the owner as per (2) above.

e. A lease agreement may be assigned and transferred (assumed) for Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984, (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.

(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider's reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per Section V.D.1. of this plan.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3.b. and 6. below. All provisions of the Title XVIII of the S.S.A. and CMS-PUB.15-1 regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets.

For purposes of this plan, a change in ownership of assets occurs when unrelated parties; purchase the depreciable assets of the facility, or purchase l00 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased

corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occurs, and if a bona fide sale is established, the provider's basis for depreciation shall be the lower of:

(1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 and determined by an appraiser who meets the requirements of Rule 61J1-4 and 61J1-6, Florida Administrative Code.;

(2) The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that began operation after July 18, 1984; or

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

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

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

4. Limitation on interest expense for property-related debt and return on equity or use allowance.

At a change of ownership on or after July 18, 1984, the interest cost and return on equity or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. above. The new owner shall be allowed the lesser of actual costs or interest cost and return on equity cost or use allowance in amounts that

would have occurred based on the allowable depreciable basis of the assets. These limited amounts shall be determined as follows:

a. The portion of the equity balance that represents the owner's investment in the capital assets shall be limited for purposes of calculating a return on equity or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b. above.

b. The amount of interest cost due to debt financing of the capital assets shall be limited to the amount calculated on the remainder of the allowable depreciable basis after reducing that allowable basis by the amount allowed for equity in a. above. The new owner's current terms of financing shall be used for purposes of this provision.

Example 1: The first owner of record after July 18, 1984, has an acquisition cost of $600,000.00. The new owner pays $1,000,000.00 for the facility, makes a down payment of $200,000.00 and finances $800,000.00 at 15 percent for 25 years. The basis for depreciation to the new owner is $600,000.00, and the disallowed portion of the depreciable basis is $400,000.00. Therefore, the allowable equity attributable to investment in the capital assets is $200,000.00, and interest cost allowed shall be computed on $400,000.00 ($600,000.00 minus $200,000.00) at 15 percent over 25 years.

Example 2: If the new owner above had made a down payment of $700,000.00 and financed $300,000.00, the allowable equity would be $600,000.00, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984, shall not be considered allowable costs for the provider's Medicaid reimbursement purposes, to the extent that such costs were

previously reimbursed for that facility under a former owner. Such costs include legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991. Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example below, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

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

H. Recapture of depreciation resulting from sale of assets.

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Title XVIII of the S.S.A., indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to a provider prior to reimbursement under the FRVS shall be determined as follows:

a. The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983, shall be subject to the same 12 1/3 year depreciation recapture phase-out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows:

(1) For each part of the facility, determine the proportion of beds to the facility's total number of beds.

(2) Multiply the proportion of beds in that part of the facility by the sales price.

(3) The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000
Older Portion of facility:
Number of beds = 60
Newer portion of facility:
Number of beds = 120
Allocation to older portion: (60/180) x 6,000,000 = $2,000,000
Allocation to new portion: (120/180) x 6,000,000 = $4,000,000
Sale Price $6,000,000

b. The adjusted gross recapture amounts as determined in a. above shall be allocated for fiscal periods from January 1, 1972, through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

c. The net recapture overpayment amount, if any, so determined in b. above shall be paid by the former owners to the State. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from future payments by the Agency to the buyer until net recapture has been received. The Agency shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation recapture resulting from leasing facility or withdrawing from the Medicaid program. In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Medicaid provider. After April 1, 1983, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the Agency creating an equitable lien on the owner's nursing home assets.

This lien shall be filed by the Agency with the clerk of the Circuit Court in the Judicial Circuit within which the nursing home is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the Agency upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid program, the reduction in the gross depreciation recapture amount calculated in Section III.H.1.a. above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients.

EXAMPLE: An owner-operator participates in Medicaid for 60 months. He then withdraws from the Medicaid program and leases the facility to a new operator, who enters the Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Medicaid program and operates the facility for another five years, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be (60 + 24 - 48)=36 months times 1.00 percent. If a provider fails to sign and return the contract to the Agency, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method.

1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the provider.

2. Upon sale of assets, recapture of reimbursement due to indexing under FRVS shall be determined as follows:

a. The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the provider has been reimbursed under FRVS;

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

3. Documented costs of replacement equipment purchased subsequent to the date the provider began reimbursement under FRVS shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity.

An allowance of a reasonable return on equity (ROE) for capital invested and used in providing patient care is includable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Medicaid Program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. ROE shall exclude positive net working capital (an amount greater than zero). For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full return on equity payment shall be calculated on 20 percent of the FRVS asset valuation per Section V.D.1.e. of this plan and included in the FRVS rate.

K. Use Allowance.

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the plan as an

allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in Chapter 12, CMS-PUB.15-1 established in Section J. above, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including government owned or operated facilities, all provisions of J. above, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.

L. Legal Fees and Related Costs.

In order to be considered an allowable cost of a provider in the Florida Medicaid Program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If, on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal, as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and the Agency, relating to Medicaid audits and Medicaid cost reimbursement cases, including administrative rules, , and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. The direct care component shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who

deliver care directly to residents in the nursing home facility. Direct care staff does not include nursing administration, MDS and care plan coordinators, staff development, and staffing coordinator. There shall be no costs directly or indirectly allocated to the direct care component from a home office or management company for staff who do not deliver care directly to residents in the nursing home facility.

N. All other patient care costs shall be included in the indirect care cost per diem rate..

O. Effective April 1, 2009, the Nursing Home Quality Assessment Fee (NHQAF) is an allowable cost and shall be included in the cost report with required adjustments. Refer to Section V. I. of this Plan for specific details of this fee. Nursing home facilities may not create a separate line–item charge for the purpose of passing through the assessment to residents.

IV. Standards

A. In accordance with Chapter l20, F.S., Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. For purposes of establishing reimbursement ceilings, each nursing home within the state shall be classified into one of six reimbursement classes as defined in V.A.2. and V.A.3. of this plan. Separate operating, direct care, and indirect care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling of $13.6500 for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5. except as noted in Section V.B.6.b.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January l and July l. The most current acceptable cost reports received by the Agency, Bureau of Medicaid Program Analysis, Audit Services by the close of the business day on October 31 and April 30 of each year or by the close of the next business day if October 31 or April 30 fall on a weekend, and

the provider's most recent reimbursement rates shall be used to establish the operating, direct care, and indirect care ceilings. Ceilings shall be set at a level, which the State determines to be adequate, to reimburse a provider for the allowable and reasonable costs of an economically and efficiently operated facility. The statewide property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan, pending transition to payments based on the FRVS, shall be $13.6500 except as noted in Section V.B.6.b. The operating, direct care, and indirect care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating, direct care, and indirect care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates.

D. Supplemental Payments for Special Care

In order to receive a supplemental payment in excess of the class ceilings, a provider must demonstrate to the Agency that unique medical care requirements exist which require extraordinary outlays of funds. Circumstances which shall require such an outlay of funds in order to receive a supplemental payment shall be limited to:

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

The period of reimbursement in excess of the class ceilings shall not exceed six months. A flat rate shall be paid for the specific patients identified, in addition to the per diem paid to the provider. The flat rate payment for medically fragile patients under age 21 who require skilled nursing care shall be trended forward each rate semester using the Global Insight indices used to compute the operating and patient care ceilings. These incremental costs shall be included in the cost reports submitted to the Agency, but shall not be included in the calculation of future prospective rates. The cost of medically fragile patients under age 21 who require skilled nursing care, shall be adjusted out based upon the flat rate payments made to the provider, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider

from the Bureau of Medicaid Services. The class ceilings may also be exceeded in cases where Medicaid patients are placed by the Agency for Health Care Administration in hospitals or in non-Medicaid participating institutions on a temporary basis pending relocation to participating nursing homes, for example, upon closure of a participating nursing home. The CMS Regional Office shall be notified in writing at least l0 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. The Agency shall extend the class ceiling exception for subsequent six-month periods upon making a determination that a need for the exception still exists and upon providing the CMS Regional Office with another advance written notification as stated above.

E. FRVS shall be used to reimburse facilities for property. To prevent any provider from receiving lower reimbursement under FRVS than under the former method where depreciation plus interest costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in Section V.D.1.h. At that time, a provider shall begin reimbursement under the FRVS. Providers entering the program after October 1, 1985, that had entered into an arms length (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985, shall be eligible for the hold harmless clause per Section V.D.l.h.

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

1. An error was made by the Agency in the calculation of the provider's rate.
2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be granted unless the amended cost report shall cause a change of one or more percent in the total

reimbursement rate. The provider shall submit documentation supporting that the one percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by the Agency in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report, the date of the first field audit exit conference for the period being amended, or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs in those reports.

G. The Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology in Section V. of this plan.

H. Reimbursement of operating, direct care, and indirect care costs are subject to class ceilings. Property costs are subject to statewide ceilings of $13.6500 for facilities being reimbursed under Section III.G.3.-5. of this plan except as noted in V.B.6.b. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per Section V.D.1.g. of this plan. Return on equity and use allowance are passed through and are not subject to a ceiling.

I. A M.A.R. shall be made pursuant to Section V.E. of this plan.

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

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition,

replacement, allowable lease cost increase or repair would cause a change of one percent or more in the provider's total per diem reimbursement rate. For providers being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on January 1 and July 1 of each year per Section V.D.1.i.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

   a. If new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by the Agency and shall be the basis for establishing reasonable cost parameters.

   b. In cases where new state or federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

   c. Interim rate adjustments shall be granted to reflect increases in the cost of general or professional liability insurance for nursing homes if the change in

cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

d. Interim rates shall not be granted for fiscal periods that have ended, such asafter the close of the provider's reporting year in which the additional costs were incurred.

e. Interim rates for the staffing requirements shall not be granted.

3. Interim rate requests must be submitted within 60 days after the costs are incurred, and shall be accompanied by a l2 month budget that reflects changes in services and costs. These interim rate requests shall be submitted to the Agency, Bureau of Medicaid Program Finance, Cost Reimbursement – Nursing Homes, 2727 Mahan Drive, MS 23, Tallahassee, FL 32308. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date the Agency receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate as limited by the effective ceiling. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, the Agency, Bureau of Medicaid Program Finance shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the Agency, Bureau of Medicaid Program Finance shall approve or disapprove the interim rate request within 60 days. If the the Agency, Bureau of Medicaid Program Finance does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement.

The Interim Rate settlement will adjust targets so the new interim cost, that otherwise would not have been reimbursed, can now flow through provider specific targets (see Section V.B.14) going forward from the interim effective date. The settlement will also adjust the actual Medicaid cost against estimated cost from the effective interim date until the cost report containing the interim cost is used to set rates. The actual Medicaid Adjustment, Line 5a of the rate sheet, is settled by: (Schedule S, line 6 of the cost report / Total Patients Days from Interim date till FYE). The Provider Specific Target Adjustment, Line 7a of the rate sheet, is settled by: [(Schedule S, line 6 of the cost report / Total Patients Days from Interim date until FYE cost report used to settle) + (Schedule S, line 7 of the cost report / Total Patients Days of cost report used to settle)]. Overpayment as a result of the difference between the approved budgeted interim rate and the revised rate using the actual costs of the budgeted item shall be refunded to the Agency. Underpayment as a result of the difference between the budgeted interim rate and the revised rate using the actual costs shall be paid to the provider.

K. Aggregate Test Comparing Medicaid to Medicare 42 CFR 447.272 provides that states must ensure CMSs that the Medicaid agency's estimated average proposed payment rate pay no more in the aggregate by category for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles, the following steps shall be taken for that rate semester, in order, as necessary to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate semester. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below the initial per diem

the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, return on equity, taxes, insurance, and home office.

2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.

3. If provisions 1 and 2 above are implemented in order to meet the upper limit test, for a period of one year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

L. Payments made under this plan are subject to retroactive adjustment if approval of this plan or any part of this plan is not received from CMS. The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by CMS.

V. Method

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

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January l and July l. The most current acceptable cost reports received by the Agency, Bureau of Medicaid Program Analysis, Audit Services by the close of the business day on October 31 and April 30 of each year or by the close of the next business day if October 31 or April 30 fall on a weekend, and the provider's most recent reimbursement rates shall be used to establish the operating, direct care, and indirect care ceilings. The statewide property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan, pending transition to payments based on the FRVS, shall be $13.6500 except as

noted in V.B.6.b. For those facilities being reimbursed under FRVS, the cost per bed ceiling per Section V.D.7 of this plan shall be used.

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

   a. Class 1 Small Size l-l00 beds - Northern Florida Counties

   b. Class 2 Large Size l0l-500 beds - Northern Florida Counties

   c. Class 3 Small Size l-l00 beds - Southern Florida Counties

   d. Class 4 Large Size l0l-500 beds - Southern Florida Counties

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

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

   All remaining Florida Counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

   a. Class 5 Small Size 1-100 beds - Central Florida Counties

   b. Class 6 Large Size 101-500 beds - Central Florida Counties

   The "Central Florida Counties" shall be comprised of:

Brevard	Manatee	Pinellas
Hardee	Orange	Polk

Highlands	Osceola	Seminole
Hillsborough	Pasco	

The "Northern Florida Counties" and "Southern Florida Counties" shall be comprised of the counties enumerated in Section V.A.2. less the "Central Florida Counties" as defined above.

B. Setting prospective reimbursement per diems and ceilings.

In determining the class ceilings, all calculations for Sections V.B.1.-V.B.14. shall be made using the four classes, and "Northern Florida counties" and "Southern Florida counties" definitions of Section V.A.2. above. All calculations for Sections V.B.15. - V.B.16. shall be made using the six classes and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in Section V.A.l. above to reflect the result of desk or on-site audits, if available.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

3. Determine total allowable Medicaid cost

   a Determine allowable Medicaid property costs, operating costs, direct care costs, indirect care costs, and return on equity or use allowance. Direct and indirect care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, except for property costs and return on equity or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K. Beginning with the January 1, 2007 rate semester, for those providers that do not meet the CNA staffing requirements of a minimum 2.7

hours per patient day with a 2.9 hours per patient day weekly average effective January 1, 2007, (hereinafter referred to as the 2007 CNA staffing requirements) based upon the provider's most recent cost report with a fiscal year beginning prior to January 1, 2007, each prospective provider's direct care subcomponent shall be adjusted or grossed up in compliance with the revised staffing requirements. This adjustment will be based on the information provided by each provider in the most recent cost report used to establish the Medicaid per diem rate for the current rate semester. The total reported productive hours for CNAs will be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for CNA nursing service. Gross up factors will be calculated for CNA hours by dividing the greater of hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by month) into the 2007 CNA staffing requirements. The nursing CNA weighted minimum requirement shall be weighted by days and the 2007 CNA staffing requirements after January 1, 2007, using the time period defined in the cost report used to set the respective rate. Facility direct care CNA costs will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

b Effective July 1, 2010 a minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.9 hours of direct care per resident per day is required. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. A minimum certified nursing assistant staffing of 2.7 hours of direct care per resident per day is required. A facility may not staff below 1 certified nursing

assistant per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day is required. A facility may not staff below 1 licensed nurse per 40 residents. No gross up adjustment will be generated due to the July 1, 2010 staffing revisions because the revisions do not increase the minimum staffing requirements.

c Effective July 1, 2011, a minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day is required. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day is required. A facility may not staff below 1 certified nursing assistant per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day is required. A facility may not staff below 1 licensed nurse per 40 residents. No gross up adjustment will be generated due to the July 1, 2011 staffing revisions because the revisions do not increase the minimum staffing requirements.

4. Calculate per diems for each of these five cost components listed in Step 3.a. above by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.D. of this plan.

5. Adjust a provider's operating, direct care, and indirect care per diem costs that resulted from Step 4. above for the effects of inflation by multiplying these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Nursing Home Cost Inflation

Index is displayed in Appendix A. Only providers being paid a prospective rate under Section V.B.6. shall be eligible for the M.A.R.

6. The statewide property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan, pending transition to payments based on the FRVS, shall be:

   a The statewide property cost per diem ceiling is $13.6500.

   b A provider is subject to a weighted average property ceiling at the addition of beds at 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average rate shall be computed, equal to the sum of:

      (1) Actual per diem costs to the provider of the original facility, limited by the property ceiling $13.6500, multiplied by the ratio of its current beds to total facility beds; and

      (2) Actual per diem costs to the provider of the facility addition, limited by the property ceiling $18.6230, multiplied by the ratio of its new beds to total facility beds.

      This weighted average rate shall be effective for 18 months from the date the additional beds were put into service.

7. Determine the median inflated operating, direct care, and indirect care costs per diems for each of the four-classes and for the whole State. For each of the per diems, calculate the ratios for each of the four-class medians to the State medians.

8. Divide individual provider operating, direct care, and indirect care cost per diems that resulted from Step 4. by the ratio calculated for the provider's facility class in Step 7.

9. Determine the statewide median for the per diems obtained in Step 8.

10. For each of the operating, direct care, and indirect care per diems, exclude the lower and upper 10 percent of the per diems of Step 8. and calculate the standard deviation for the remaining 80 percent.

11. Establish the statewide cost based reimbursement ceiling for the operating cost per diem as the sum of the median plus one standard deviation and for the direct care and indirect care cost per diems as the sum of the median plus 1.75 standard deviations that resulted from Steps 9. and 10., respectively.

12. Establish the cost based class reimbursement ceilings for:

    (a) The operating, direct care, and indirect care costs per diems for Classes 1 – 4 as defined in Section V.A.2. by multiplying the statewide ceilings in Step 11 times the ratios calculated for that class in Step 7.

    (b) The operating, direct care, and indirect care cost per diems for Classes 5 and 6 as defined in Section V.A.3. as the arithmetic average of the reimbursement ceilings determined in a. above.

13. Establish the effective class reimbursement ceilings for operating, direct care, and indirect care cost per diems for each class as the lesser of:

    a. The cost based class reimbursement ceiling determined in Step 12.

    b. The target rate class reimbursement ceiling as calculated in 13.b., from the previous rate semester, inflated forward with 1.4 (the class target inflation multiplier) times the rate of increase in the Florida Nursing Home Cost Inflation Index through a calculation similar to that given in Step 14. No reimbursement ceiling can increase in excess of 15 percent annually. The direct care component shall not be limited to the target rate class reimbursement ceiling. The target rate class reimbursement ceiling shall not fall below 90 percent of the cost based class ceiling for each rate semester as calculated in Step 12.

14. Establish the provider target reimbursement rate for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for

operating and indirect care cost in Step 14. from the previous rate semester, excluding the M.A.R., with the quantity:

$$1 + 2.0 \text{ X } \frac{\text{Florida Nursing Home Cost Inflation Index (at the midpoint of the prospective rate period -1)}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}}$$

In the above calculation the 2.0 shall be referred to as the provider specific target reimbursement rate inflation multiplier. The provider target reimbursement rate limitation shall not fall below 75 percent of the cost based class reimbursement ceiling for each rate setting as calculated inStep 12. The direct care component shall not be limited to the target reimbursement.

15. Compute the total cost-related per diem for a provider as the sum of:

(a) The lesser of the operating cost per diem obtained in Step 5., the provider's operating provider target rate in Step 14., the effective operating class ceiling obtained in Step 13., or the provider's operating new provider target limitation per diem obtained in Section I.B.

(b) The lesser of the direct care cost per diem obtained in Step 5. or the direct care cost based class ceiling obtained in Step 12.

(c) The lesser of the indirect care cost per diem obtained in Step 5., the provider's indirect care provider target rate in Step 14., the indirect care effective class ceiling obtained in Step 13., or the provider's indirect care new provider target limitation per diem obtained in Section I.B.

(d) The lesser of the property cost per diem obtained in Step 5. or the applicable statewide property cost per diem ceiling in Step 6. for facilities not reimbursed under FRVS. For those reimbursed under FRVS, substitute the FRVS rate calculated per Section D. below, which shall be the sum of the property tax

(which excludes sales tax on lease payments), insurance, and home office passthrough per diems plus the per diem calculated based on the indexed 80 percent asset value plus the ROE or use allowance per diem calculated on the indexed 20 percent asset value.

(e) Return on equity per diem obtained in Step 4.

(f) The M.A.R. add-on as described in E. below.

16. Establish the prospective per diem for a provider as the result of Section V. B.

C. Medicaid Trend Adjustments (MTA)

The MTA is a percentage cut that is uniformly applied to all Medicaid providers each rate semester which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is applied to all components after targets and ceilings. Below are all the recurring and non recurring cuts that are included in the MTA. Please reference Appendix C for each MTA percentage by rate semester.

1. Effective July 1, 2005, a recurring annual reduction of $25,853,709shall be applied proportionally to all rates.
2. Effective January 1, 2008, an additional MTA shall be applied to achieve a recurring annual reduction of $75,182,326.
3. Effective January 1, 2009, the Agency shall implement a recurring methodology to reduce nursing home rates to achieve a reimbursement rate reduction of $83,847,252. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

4. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

5. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology to reduce individual nursing home rates proportionately until the $231,362,589 required savings is achieved.

6. Effective July 1, 2009, the Agency shall implement a recurring methodology in the Title XIX Nursing Home Reimbursement Plan to reduce nursing home rates to achieve an $81,333,369 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

7. Effective July 1, 2009, the Agency shall implement a recurring methodology in the Title XIX Nursing Home Reimbursement Plan to reduce nursing home rates to maximize the Nursing Home Quality Assessment Fee (NFQAF) which will vary based on legislative authority for the assessment, Federal Medical Assistance Percentage (FMAP), and other reductions that have priority. This reduction will only occur if there are sufficient funds in the Nursing Home Quality Assessment to restore the reduction. Please refer to Section V.I. for a complete description of the methodology used in establishing the NFQAF.

8. Effective July 1, 2011, budget authority up to $187,751,660 is provided for modifying the reimbursement for nursing home rates. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In

establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

9. Effective July 1, 2011, the agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs. Reimbursement rates shall be as provided in the General Appropriations Act.

10. Effective July 1, 2012, the Agency shall implement a recurring methodology in the Title XIX Nursing Home Reimbursement Plan to reduce nursing home rates to achieve a $35,160,584 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

D.

1. FRVS for providers in existing facilities at October 1, 1985.

   a. Each provider in an existing facility, at October 1, 1985, shall have an FRVS rate established for capitalized tangible assets based upon the assets' acquisition costs at the last dates of acquisition prior to July 18, 1984. Facilities purchased after July 18, 1984, and not enrolled in the Medicaid program prior to the purchase or facilities constructed after July 18, 1984, and enrolled in the program shall have an FRVS rate established on the basis of the last acquisition costs prior to enrolling in the Medicaid program. The acquisition costs shall be determined from the most current depreciation schedule which shall be submitted by each provider. These acquisition costs, including the cost of capital improvements and additions subsequent to

acquisition, shall be indexed forward to October 1, 1985, by a portion of the rate of increase in the Florida Construction Cost Inflation (FCCI) Index based on the Dodge Construction Index. The change in the FCCI Index from September 1984 to March 1985, shall be used to project the FCCI Index for October 1, 1985, with no subsequent retroactive adjustment. The costs of land, buildings, equipment, and other capital items allowable for Medicaid reimbursement per CMS-PUB.15-1, such as construction loan interest expense capitalized, financing points paid, attorneys' fees, and other amortized soft costs associated with financing or acquisition shall be included in determining allowable acquisition costs subject to indexing. Property taxes (which exclude sales tax on lease payments) and property insurance expenses shall not be included in the calculation of the FRVS rate, but shall be reimbursed prospectively, based on actual costs incurred and included in the total property rate. For FRVS rates calculated after October 1, 1985, but prior to July 1, 1991, the six month change in the FCCI Index based on the Dodge Construction Index shall be determined for adjusting FRVS rates. For rates effective on or after July 1, 1991, the FCCI Index based on the Global Insight /McGraw - Hill Health Care Costs, Consumer Price Index All Urban All Items South Region shall be used. FRVS rates shall be adjusted for inflation on each January 1 and July 1, using the change in the FCCI Index for the most recent six-month period published prior to the rate semester. FRVS rates shall be adjusted per subsections f. and i. below for changes in interest rates on capital debt instruments and for capital additions or improvements on each January 1 and July 1. (See Appendix B for computation of the index).

b. A single FCCI Index, based upon the average of the Dodge Construction indices for the six cities in Florida for which an index is published, shall be used through June 30, 1991, and the most recently published Global Insight Health Care Costs All

Urban All Items South Region Index quarterly indices shall be used for July 1, 1991, and thereafter. The rate of increase in the FCCI Index, for purposes of indexing FRVS rates, shall be limited to a three percent semi-annual increase. During semesters when the increase in the index is greater than three percent, a credit calculated as the actual increase minus three percent, shall be carried forward for future periods and added to the increase in the index, up to a maximum of three percent, when the actual future increases in the index are less than three percent. For example, if the increase in the index is four percent in period one, three percent shall be used and a credit of one percent shall be carried forward; then, if the increase in the index is two percent in period two, a three percent rate of indexing shall be used, by adding the one percent credit to the actual two percent increase. If more than two percent credits were available, a maximum of three percent rate of indexing would be used, and the remaining credits would again be carried forward to future periods. The credits shall carry forward indefinitely until they are reduced by applying them to periods during which the rate of increase in the FCCI Index is less than three percent. The credits shall accrue by individual facility, so that any facility entering the program in a period where the increase in the FCCI Index is less than three percent shall not benefit from credits accrued during prior periods by other facilities.

c. The portion of the FCCI Index increase used to index asset valuation each year shall vary with the number of years the facility participated in the program since January 1, 1972. For the first 10 years of participation, a straight-line increasing portion of the allowable increase in the index shall be used: 1/10 in year one, 2/10 in year two, 3/10 in year three, up to 10/10 in year 10. The total percent increase allowed for any six-month rate semester shall not exceed three percent. For the second 10 years, the unadjusted index increase shall be used, subject to a three-percent semi-annual

limitation. For the next 20 years, years 20 through 40, a straight-line decreasing portion of the allowable increase in the index shall be used subject to the three-percent limit per rate semester: 95 percent in year 21, 90 percent in year 22, 85 percent in year 23, down to 0percent in year 40. Thus, after 39 years of participation in the program, no further indexing shall be given to a facility.

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

1) Any facility which receives a conditional licensure rating and upon re-inspection has not corrected deficiencies as required by the the Agency, Bureau of Long Term Care Services, shall receive no indexing in the FRVS rate for the six-month rate period subsequent to the re-inspection.

2) Medicaid utilization shall be calculated as Medicaid patient days divided by total patient days, for fiscal years ending in 1980 or after. The utilization will be calculated from the cost report or budget used to set the rates for the respective rate semester. For the initial FRVS rates established on October 1, 1985, cost reports received by the Agency by September 1, 1985, will be used. Years earlier than 1980 shall have no adjustment made for utilization, but rather shall receive full credit for Medicaid utilization. The adjustment for fiscal years ending in 1980 or after shall be computed as follows: if the provider's cost report or budget shows less than 25 percent average Medicaid utilization for the cost reporting period, then no indexing of asset valuation shall be given; if 25 percent to 55 percent Medicaid utilization is computed, then the portion of the FCCI Index increase calculated in subsection 1.c.

above shall be multiplied by the fraction equal to the actual utilization percent divided by 55 percent; if 55 percent or greater Medicaid utilization is computed, then full indexing using the portion of the FCCI Index increase calculated in subsection 1.c. above shall be given.

e. The asset valuation of the facility shall be indexed, according to a.-d. above, from the date of entry into the Medicaid program but not prior to January 1, 1972, to October 1, 1985. That asset valuation, subject to the cost per bed ceiling in g. below, shall be used to initiate the provider's FRVS property reimbursement at October 1, 1985. The change in the FCCI Index from September 1984, to March 1985, shall be used to project the FCCI Index for October 1, 1985, with no subsequent retroactive adjustment. The total asset valuation shall be divided into two components: 80 percent of the total asset valuation shall be amortized over 20 years, at the interest rate specified in 6. below, to determine an amount which would pay principal and interest on an installment mortgage for that 80 percent of the asset valuation. For providers with facilities beginning FRVS with a total initial principal balance of all current mortgages less than 60 percent of the indexed asset value, only the interest portion will be used in calculating the provider's FRVS rate. The calculated interest plus principal or interest only expense will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility. However, for providers with newly constructed facilities, the provider's per diem calculated for that facility's first year of operation shall be the result of the principal and interest or interest only expense divided by 75 percent of the maximum possible annual bed days. For those providers with facilities that have put into service new beds for the first 12 months, the provider's per diem shall be the result of the principal and interest or interest-only expense divided by a weighted average occupancy percentage greater than 75

percent but less than 90 percent of the maximum annual bed days if the addition of beds was 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average occupancy rate shall be computed, equal to the sum of:

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

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

Property taxes (which excludes sales tax on lease payments), insurance, and home office costs shall have a per diem calculated based upon actual historic cost and patient days as shown in the latest applicable cost report. Twenty percent of the asset valuation shall be used to calculate a return on equity for property-related equity per Sections III.J. and K., and this return on equity shall be included as part of the FRVS rate. This will be converted to a provider's per diem by dividing by 90 percent of the maximum annual bed days of the facility and by 75 percent of the maximum annual bed days for providers with newly constructed facilities. Again, for those providers with facilities that have put into service new beds for the first 12 months, and the addition of beds was 50 percent or more of the existing bed capacity, or the addition of 60 beds or more, the twenty percent will be converted to a per diem by dividing by a weighted average occupancy percentage greater than 75 percent but less than 90 percent of the maximum annual bed days as explained in (1) and (2) above.

f. Mortgages and Interest Rates

A. The interest rate used to amortize the 80 percent component of the asset valuation shall be the lower of: the owner's actual mortgage rate; the Chase

Manhattan Bank's prime rate, hereinafter referenced as Chase prime, as of the date of the provider's loan commitment plus two percent for a variable-rate mortgage or plus three percent for a fixed mortgage rate; or 15 percent. If an owner has more than one outstanding debt instrument, the owner's actual rate used for this section shall be an average of the rates for all of the outstanding debt, weighted by the amount of the original principal of each debt instrument.

B. No changes subsequent to establishment of the initial FRVS rate shall be made to the interest rate used to calculate the FRVS rate for providers with fixed-rate mortgages except as allowed per (5) below. For variable-rate mortgages, no changes shall be made unless the owner's interest rate changes according to (3) below.

C. For the initial FRVS rates at October 1, 1985, the July 1, 1984, Chase prime shall be used for the lesser of comparison with the provider's actual rate. For those providers that received the July 1, 1984, Chase prime (13 percent) at June 30, 1996, (referenced above) beginning with the July 1, 1996, rate semester, these same providers shall have 12.5 percent used for the lesser of comparison on and after July 1, 1996. For rate semesters prior to July 1, 1996, these same providers shall remain at 13 percent. Providers shall be required to notify the Agency of their mortgage rate and any changes in their mortgage rate. Providers with variable mortgage rates shall submit current changes in their mortgage rates by October 15 and April 15 of each year to qualify for an adjustment to their FRVS rate on the following January 1 or July 1, respectively. At that time, the FRVS rate to be used for the next six-month rate semester beginning January 1 or July 1 shall be

determined using the most current mortgage rate, but not to exceed the October 15 or April 15, respectively, Chase prime plus two percent, or 15 percent.

D. For facilities beginning the FRVS with a total initial principal balance of the mortgages less than 60 percent of their indexed asset value, the interest rate used to amortize the 80 percent component shall be the applicable Chase prime as detailed above, but not to exceed 15 percent. The amortization of prime over 20 years shall be used to determine an amount which would pay interest on an installment mortgage for that 80 percent valuation. The prime rate used to initiate FRVS for providers with an initial principal balance of the mortgage less than 60 percent of their indexed asset value shall remain fixed for that provider in calculating future FRVS payments. However, if at some point in the future a provider finances capital assets such that the total original principal of debt instruments equals or exceeds 60 percent of the FRVS asset valuation, then the FRVS rate at the next rate semester shall be calculated using the interest rate per (1) above.

E. An increase in the interest rate shall be allowed only if refinancing was necessary in order to finance the addition of new beds, to meet the final payments of the former debt instrument, or to consolidate existing debt excluding debt to owners; for example, in cases where balloon payments are due. If a new mortgage is secured at the addition of new beds and a prior mortgage is still in effect for the original facility, a weighted average mortgage rate shall be used in (1) above based upon mortgage amounts and interest rates of the various mortgages.

g. The standard, or ceiling, per bed cost shall be established at $28,500.00 at October 1, 1985. Each existing facility at October 1, 1985, shall have its total capital assets valuation limited to that standard or the facility's computed asset valuation, whichever is less. The standard of $28,500.00 shall be indexed forward every 6 months based upon the most recently published 6 month full increase in the FCCI Index and shall be used to limit new construction costs in the future. New facilities shall be limited to the standard in effect six months prior to the date the facility was first put into service as a nursing home. A facility shall not receive an adjustment to account for increases in the standard at later dates.

h. A hold harmless provision shall be implemented to ensure that facilities existing and enrolled in the Medicaid program at October 1, 1985, do not receive reimbursement for property and return on equity or use allowance under the FRVS method less than the property cost reimbursement plus return on equity or use allowance given at September 30, 1985. If, after calculation of the FRVS rate, that reimbursement would be lower than depreciation plus interest costs under Section III.G. 3.-5. of this plan, a provider in the facility shall continue to be reimbursed depreciation plus interest according toSection III.G. 3.-5. of this plan until such time as the net difference in total payments between Section III.G. 3.-5. and FRVS is zero. Providers who wish to begin FRVS reimbursement that would result in payments less than the depreciation plus interest payments must notify the Agency in writing by December 2, 1985. Providers in facilities with existing leases at October 1, 1985, shall be paid at the September 30, 1985 rate subject to Section III.G.2. until the current lease expires, at which time reimbursement shall begin under FRVS based on the owner's acquisition costs. Providers shall supply the Agency with the appropriate lessor's ownership costs to receive property reimbursement after the

current lease expires. No reimbursement for property-related costs shall be given to a provider in a leased facility subsequent to the expiration of the lease existing at October 1, 1985, if the lessor's ownership costs are not adequately documented per Section III.G.4. of this plan.

i. No adjustments to asset valuation shall be made for replacement of existing equipment. Adjustments at cost shall be allowed for capital improvements and additions. Capital additions of beds shall be subject to the per bed standard as computed in g. above that is in effect six months prior to the date the facility addition was first put in service as a nursing home. An adjustment to the FRVS rate may be requested if expenditures for capital additions and improvements totaling $0.40 per available bed day accrue in the cost reporting period utilized in establishing the per diem rate for the upcoming rate semester. Costs incurred during a cost reporting period that do not total $0.40 per available bed day shall not be included in the next cost reporting total. Thus, a provider in a 120-bed facility purchasing new equipment which does not replace any old equipment, and making capital improvements at a total unamortized purchase cost less than $17,520 during a 12 month cost reporting period shall not receive an adjustment to the FRVS rate in the coming rate semester or in any rate semester for those improvements or equipment. The cost of capital additions or improvements shall be established on the date new beds are put into service, the date of completion for capital improvements, and date of acquisition for equipment or other purchased assets and recognized for FRVS purposes so long as the total indexed asset valuation does not exceed the current per bed standard except as provided below:

1) In no circumstances, other than (1) and (2) below, shall a provider's total asset value under FRVS exceed the current per bed standard.

2) Effective July 1, 1996, providers whose indexed asset valuation exceeds the per bed standard at June 30, 1996 shall be limited to their June 30, 1996 indexed value until the rate period in which their total asset value is less than the current per bed standard.

3) Providers that entered into a legally enforceable arm's length agreement prior to July 1, 1996 for the construction or purchase loans of additions (excluding bed additions) or improvements which were not previously reported in a cost report shall have those additions or improvements included in their indexed asset value when the cost report that includes those additions or improvements is used to establish the reimbursement rate. When the above mentioned additions or improvements cause the providers indexed asset value to exceed the current per bed standard, the provider shall be limited to that indexed asset value until the rate period in which that indexed asset value is less than the current per bed standard. Documentation of the legally enforceable, arms length agreement must be submitted with the cost report in which the additions or improvements are reported.

4) Any cost associated with capital additions or improvements, which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate. Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by the Agency.

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

a. The FRVS rate for providers in facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Medicaid program subsequent to

October 1, 1985 shall be calculated as in Section V.D.a.-g. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under Section III. G. 2.-5.

b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect six months prior to the date the facility was first put into service as a nursing home. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to six months prior to the date the facility was first put into service as a nursing home but not prior to January 1, 1972.

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

d. Facilities that participate in the Medicaid program on or after October 1, 1985, but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.

e. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40-year indexing curve per Section D.1.c. above when it withdrew from the program.

3. Property reimbursement for facilities upon change of ownership.

a. Facilities that undergo a change of ownership on or after October 1, 1985, shall be reimbursed for property based upon the provisions contained in this section. It is the Agency's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider. Therefore, unless stated otherwise in b.-f. below, the new provider's reimbursement shall be based on Section D.1.a.-c. above.

b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of Section D.1.h. above, the new owner shall also receive depreciation plus interest per Section III.G. unless the new owner requests the Agency, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in D.1.f. above.

c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less than 60 percent of the indexed asset value, only the interest portion, at a rate determined in Section D.1.f., will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in Section D.1.f. above. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at Sectiom D.1.f. above. Any credits accrued by the previous owner for indexing as described in Section D.1.b. above shall be applied to the new owner.

d. The return on equity or use allowance shall be calculated as per Section D.1.e. above. A per diem shall be calculated for property taxes, insurance, and home office costs based upon actual historic cost and patient days shown in the latest applicable cost report, as per Section D.1.e. above.

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

f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider.

4. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

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

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost, which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

E. Medicaid Adjustment Rate (M.A.R.)

The M.A.R. for Direct Care and Indirect Care shall be calculated as follows:

1. Facilities with 90 percent or greater Medicaid utilization shall have their M.A.R. equal their WBR as determined in Section E.3 below.

2. Facilities with 50 percent or less Medicaid utilization shall receive no M.A.R.

3.Facilities between 50 percent and 90 percent Medicaid utilization shall have their M.A.R. as determined by the following formula:

M.A.R. = WBR x MA

WBR = (BR x MAW) X ((Superior + Standard)/All).

MA = ((Medicaid Utilization % - MIN)/(MAX-MIN))

Definitions:

M.AR. = Medicaid Adjustment Rate

WBR = Weighted Base Rate

MA = Medicaid Adjustment

BR = Base Rate, which is set as the result of Section V.B.17.b. and c.

MAW = Medicaid Adjustment Weight, which is set at .045

Superior = Number of Superior Days as described in 4. below.

Standard = Number of Standard Days as described 4. below.

All = All superior, standard, and conditional days

MIN = Minimum Medicaid Utilization Amount which is set at 50 percent

MAX = Maximum Medicaid Utilization Amount which is set at 90 percent

4. Determine the number of days during the six month period one year prior to the rate semester for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

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

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

The result of these calculations will represent the M.A.R. to which the provider is entitled. This rate is to be included in the direct care and indirect care component of the provider's total reimbursement rate. Only providers being paid a prospective rate shall be eligible for M.A.R.

F. Medicaid Nursing Home Special Medicaid Payments

The Special Medicaid Payments for nursing homes will be made for qualified public, non-state owned or operated nursing homes. No payments under the Special Medicaid Payment program are being made to state government-owned or operated facilities or privately owned and operated facilities.

G. Special Medicaid Payments Calculations

The following formula, except as noted below, shall be used to make Special Medicaid Payments (SMPs) to public, non-state, nursing facilities.

SMP = [A(Beds) + B(Cost)]/2

Where:

SMP = Special Medicaid Payment

A(Beds)=Allocation Based on Individual Nursing Facility Beds

A(Beds)=TAPL*INFB/TNFB

Where:

TAPL = Total Available Payment Limit

INFB = Individual Nursing Facility Beds (for all public non-state nursing facilities being paid under this formula).

TNFB = Total number of beds for all public non-state nursing facilities being paid under this formula

B(Cost) = Allocation Based on Individual Nursing Facility Costs

B(Cost) = TAPL *FPLA / TFPLA

Where:

FPLA = Facility Payment Limit for Allocation (for all public non-state nursing facilities being paid under this formula).

TFPLA = Total of Facility Payment Limit for Allocation (for all public-non state nursing facilities being paid under this formula).

For those nursing facilities where the Medicaid per diem rate is greater than 90 percent of the facility's Medicaid per diem cost, the nursing facility shall receive a SMP of $200,000. Nursing facilities paid under this provision will not have their beds included in the formula listed above. The Agency shall use the nursing facility's Medicaid per diem costs and Medicaid rate that were effective for the January 1 rate semester.

H. Fire Safety Protection

Effective July 1, 2005, pursuant to Section 633.022, F.S., each nursing home licensed under part II of chapter 400 shall be protected by an approved, supervised automatic sprinkler system in accordance with section 9 of National Fire Protection Association, Inc., Life Safety Code. Medicaid rates shall be modified to allow pass through adjustments effective at the beginning of the first rate semester that installation of an approved sprinkler system is completed. The pass through shall be made to the provider Medicaid rate to allow reimbursement over a five-year period for Medicaid's portion of the costs incurred to meet this requirement. Costs of the sprinkler system must be removed from the provider's allowable Medicaid costs in the Medicaid

cost report and not reported for FRVS. Such costs shall be reported to the Agency separate from the Medicaid cost report.

I. Nursing Home Quality Assessment Fee (NFQAF**)**

Effective April 1, 2009, the Agency for Health Care Administration in accordance with Section 409.9082, F.S., shall implement methodologies revising reimbursement to nursing homes that will create a pass-through of the Medicaid share of the assessment, restore prior reductions as allowed, and provide for an operating add-on as a phase-in to a pricing model. The funding for reimbursement improvements is provided through the NFQAF. The funds shall exclusively be for the following purposes and in the following order of priority:

1. To reimburse the Medicaid share of the quality assessment as a pass through. The Quality Assessment Medicaid share is a pass through which is calculated as follows: take total patient days minus Medicare days to get total non-Medicare days. Then, take the product of total non-Medicare days, NFQA rate and Medicaid utilization to get total NFQA Medicaid share. Last, take the total NFQA Medicaid share and divide it by Medicaid days to equal Quality Assessment Medicaid Share.
2. To increase to each nursing home facility's Medicaid rate, as needed, an amount that restores the rate reductions effective on or after January 1, 2008. These reductions are listed in Section V.C. 2 through 10.

   To increase each nursing home facility's Medicaid rate that accounts for the portion of the total assessment not included in paragraphs 1. and 2. The rate increase is a pass though which is calculated by taking total funds reminaing after paragragh 1. and 2. Then, subtract budgeted administrative cost and funds required for Hospice restore to equal total total funds remaing in Quality Assessment. Next, divide total funds remaining in Quality Assessment by annualized Medicaid days to equal the increase to nursing home facility's Medicaid rate.

VI. Payment Assurance

The State shall pay each nursing home for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59G6.010, Florida Administrative Code, 42 CFR, and Section 1902 of the S.S.A. The payment amount shall be determined for each nursing home according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VII. Provider Participation

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

VIII. Payment in Full

Any provider participating in the Florida Medicaid nursing home program who knowingly and willfully charges, for any service provided to the patient under the State plan, money or other consideration in excess of the rates established by the State plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility or intermediate care facility, or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15.

IX. Definitions

A. Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. Agency for Health Care Administration: (AHCA), also referred to as the Agency.

C. Area: The Agency shall plan and administer its programs of health, social, and rehabilitative services through eleven service areas composed of the following counties:

1. Area 1 - Escambia, Okaloosa, Santa Rosa, and Walton counties
2. Area 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Washington, and Wakulla counties
3. Area 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwanee, and Union counties
4. Area 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties
5. Area 5 - Pasco and Pinellas counties
6. Area 6 - Hardee, Highlands, Hillsborough, Manatee, and Polk counties
7. Area 7 - Brevard, Orange, Osceola, and Seminole counties
8. Area 8 - Charlotte, Collier, Desoto, Glades, Hendry, Lee, and Sarasota counties
9. Area 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
10. Area 10 - Broward county
11. Area 11 - Dade and Monroe counties

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

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

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

G. Bed: A licensed Skilled Nursing Facility (SNF) bed.

H. CMS-PUB.l5-1: Health Insurance Manual No. l5, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

I. Cost Report Acceptance Cut-off Date: The close of the business day on October 31 and April 30 of each year or by the close of the next business day if October 31 or April 30 fall on a weekend.

J. Cost Report Due Date: A providers's cost report isdue five calendar months after the close of the provider's cost-reporting year. Initial cost reports are due 23 months after the Medicaid provider's effective date.

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

L. Facility: The physical grounds and buildings where a provider operates a licensed nursing home.

M. Late Cost Report: A cost report is late if it is not received by the Agency on the first cost report acceptance cut-off date after the cost report due date.

N. Legislative Unit Cost - The weighted average per diem of the State anticipated expenditure after all rate reductions.

O. Medicaid Adjustment Rate (M.A.R.): An add-on to the Direct Care and Indirect Care cost components of providers with greater than 50 percent Medicaid utilization to encourage high quality care while containing costs. The M.A.R. per diem calculation is detailed in Section V.D. of the Plan.

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

Q. Medicaid Nursing Home Direct and Indirect Patient Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

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

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

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

U. Provider: A person or entity licensed and/or certified under state law to deliver health care or related services, which services are reimbursable under the Florida Medicaid Program.

V. Rate Setting Unit Cost - The weighted average per diem after all rate reductions based on submitted cost reports.

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

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

Y. Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Z. Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

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APPENDIX A
CALCULATION OF THE FLORIDA NURSING HOME COST INFLATION INDEX

Based on a sample size of approximately 35 percent of the cost reports filed for the rate period beginning July 1, 2003 and approximately 25 percent of the cost reports filed for the rate period beginning January 1, 1988, the percentage weights for the cost components are estimated as:

	Effective July 1, 2004			**Prior to July 1, 2004**
Component	Direct Patient Care	Indirect Patient Care	Operating	All Components
Salaries and Benefits	100.0%	55.75%	55.75%	57.89%
Dietary	0.0%	6.23%	6.23%	5.18%
Others	0.0%	38.02%	38.02%	36.93%

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

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

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

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

= 1.03068

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

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

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

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

All monthly indices can be calculated in a similar fashion.

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

APPENDIX B
CALCULATION OF THE FLORIDA CONSTRUCTION COST INFLATION INDEX

FOR RATES EFFECTIVE ON AND AFTER 7/1/91

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

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

2. Using the South Region, divide the index corresponding to the midpoint of the currentrate period by the index of the midpoint of the previous rate period. The results shall be the inflation multiplier for the rate semester.

Example:

Rate Semester - January 1991

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

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

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

These indices will be updated semi-annually prior to each January 1 and July 1 using the current data.

APPENDIX C
Medicaid Trend Adjustment (MTA) Percentages

The following are the uniform percentage cuts for the effective rate semester listed.

Rate Semester	Uniform Medicaid Trend Adjustment	Annualized Reduction Amount		Uniform Medicaid Trend Adjustment with NFQA effect	Annualized Reduction Amount with NFQA effect
7/05	0.40%	$25,853,709		0.40%	$25,853,709
1/06	1.48%	$25,853,709		1.48%	$25,853,709
7/06	0.96%	$25,853,709		0.96%	$25,853,709
1/07	0.93%	$25,853,709		0.93%	$25,853,709
7/07	0.91%	$25,853,709		0.91%	$25,853,709
1/08	3.52%	$101,036,035		3.52%	$101,036,035
7/08	3.52%	$101,036,035		3.52%	$101,036,035
1/09	6.28%	$184,883,287		6.28%	$184,883,287
3/09	14.13%	$416,245,876		14.13%	$416,245,876
4/09	14.13%	$416,245,876		0.88%	$25,853,709
7/09	21.42%	$621,282,257		0.89%	$25,853,709
1/10	21.36%	$621,282,257		0.89%	$25,853,709
7/10	23.52%	$644,823,648		0.87%	$25,853,709
1/11	23.52%	$644,823,648		0.87%	$25,853,709
7/11	22.75%	$685,330,905		7.30%	$220,042,943
1/12	22.63%	$685,330,905		7.25%	$219,612,898
7/12	23.58%	$720,491,489		5.19%	$180,411,212
1/13	23.29%	$720,491,489		5.83%	$180,411,212
7/13	23.18%	$720,491,489		4.34%	$135,121,640

Note- Effective April 1, 2009 the Nursing Home Quality Assessment Fee (NFQAF), as referenced in Section V. I. of the plan, was implemented for the purpose of restoring the annualized recurring reductions implemented on or after January 1, 2008.

APPENDIX D

Upper Payment Limit Demonstration

Pursuant to 42 CFR 447.272, the Agency shall use a cost-based demonstration to ensure Medicaid expenditures do not exceed the Upper Payment Limit (UPL), a reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles. The UPL shall be determined separately for state government, non-state government, and privately owned or operated nursing facilities. The UPL calculation requires the compilation of Medicare and Medicaid data for all nursing facilities that participate in the Florida Medicaid program. Medicare data shall be acquired from the most recently available, filed Medicare cost report, Form #CMS 2540, from a reporting period no more than two years prior to the current rate year. The following fields from the Medicare cost report are used in the UPL calculation:

1. Total Medicare Routine Cost found on Worksheet B or Worksheet D
2. Ancillary Medicare Charges, Ancillary Medicare Cost, Drug Charges, and Drug Cost found on Worksheet C
3. Medicare Days found on Worksheet D or Worksheet S

A. Medicaid charges and days reported in the Medicaid cost reports, which are used for the July 1, 2013 rate setting, shall be used for the fiscal year 2013-14 UPL calculation. The state shall only include Medicaid charges from in-state Medicaid residents and shall exclude crossover claims, physician service charges, and other professional service charges. Estimated Medicaid expenditures for the applicable fiscal year shall be calculated based on the nursing facility per diem rates set each July and January. The average of the July and January rates will be multiplied by annualized Medicaid days to determine total estimated Medicaid expenditures. The Medicaid expenditures shall be the net actual total expenditures excluding patient responsibility. The Medicaid expenditures include base payments through Medicaid reimbursement to the provider and Nursing Home Special Medicaid Payments through supplemental payments to the provider. Base and supplemental payments shall be identified separately as private, state government, and

non-state government. The dollar amount of payments for the UPL base period shall equal the claimed amounts on the CMS-64, a quarterly expense report.

B. The total UPL for each provider shall be trended from the midpoint of the corresponding Medicare cost report to the midpoint of the state fiscal year. The data shall be trended to inflate historical Medicare costs to reflect current period expenses. The trending factors shall come from the Global Insight Healthcare Cost Review, Skilled Nursing Facility Total Market Basket, %MOVAVG.

C. The Total Trended Upper Payment Limit shall be calculated for each facility as follows:

Total Trended Upper Payment Limit = Total Upper Payment Limit × Trend Factor

Total Upper Payment Limit = Routine UPL Cost + Ancillary UPL Cost

Routine UPL Cost = (Total Medicare Routine Cost /Medicare Days) × Annualized Medicaid Days

Ancillary UPL Cost = [(Ancillary Medicare Cost - Medicare Drug Cost)/(Ancillary Medicare Charges - Medicare Drug Charges)] × Ancillary Medicaid Charges

Note: The Ancillary UPL Cost shall be calculated by removing costs and charges for drugs to account for differences in Medicare and Medicaid costs and charges.