DEPARTMENT OF HEALTH
AND HOSPITALS

ADHC
Cost Report Training

Presented by Postlethwaite & Netterville

August 13, 2013

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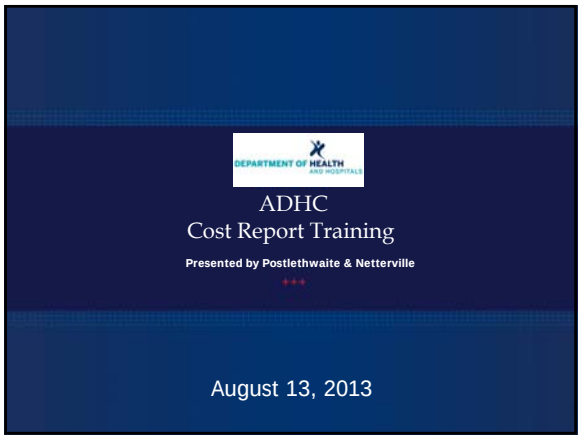
DEPARTMENT OF HEALTH
AND HOSPITALS
ADHC
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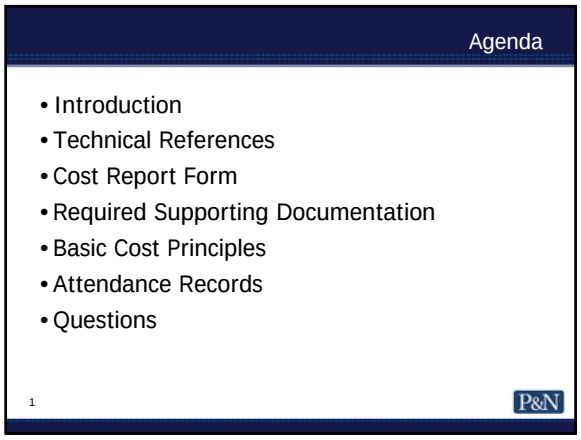
Agenda
• Introduction
• Technical References
• Cost Report Form
• Required Supporting Documentation
• Basic Cost Principles
• Attendance Records
• Questions
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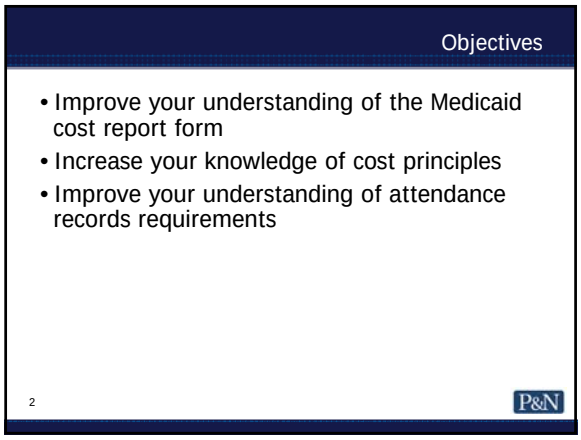
Objectives
• Improve your understanding of the Medicaid cost report form
• Increase your knowledge of cost principles
• Improve your understanding of attendance records requirements
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Technical References

- Adult Day Health Care Standards for Payment (SFP)
  - http://www.doa.louisiana.gov/osr/reg/1109/1109.pdf
    Page 2624 – September 2011
  - http://www.doa.louisiana.gov/OSR/reg/regs2008.htm
    Page 2565 – December 2008
- DHH ADHC Provider Manual
  - Published on 12/1/10
  - http://www.lamedicaid.com/provweb1/Providermanuals/ADHC_Main.htm
- Cost report form and instructions
  - Download from M&S
    - http://la.mslc.com/downloads.aspx

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Technical References

- Correspondence from DHH
  - Supplemental Payments Section/Rate and Audit Unit
    - //www.dhh.louisiana.gov/index.cfm/page/235
    - Click Publications and scan for ADHC topics
- Medicare Provider Reimbursement Manual (PRM or HIM-15)
  - www.cms.hhs.gov/Manuals/PBM/list.asp
  - Click on Pub 15-1

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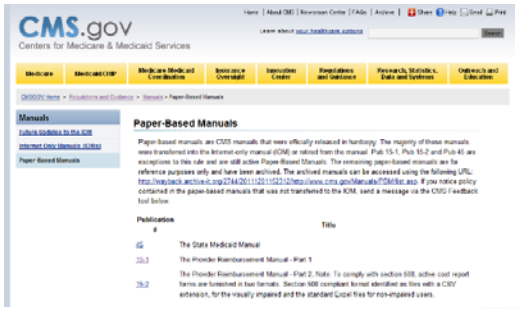
CMS Website



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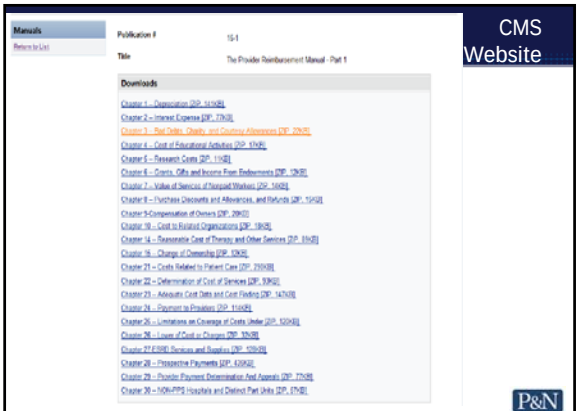
CMS Website



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Cost Report Form

- Recent Changes
  - Quarter Hours are now required on Schedule B for all payor types
  - Transportation costs are segregated in Part E on Schedule H

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Cost Report Form

- General Information
  - New excel form should be downloaded each year
  - Electronic excel file and scanned copies of attachments and signature page must be submitted to M&S
    - Submission email – LAADHC@mslc.com

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Cost Report Form

- Required attachments to Filed Cost Reports
  - Working trial balance that identifies which cost report line item an account is included in
    - Must have a subtotal for each cost report line
    - Must agree to amounts reported on cost report
  - A depreciation schedule
    - If hospital based, the schedule must clearly show Hospital only, ADHC only and shared assets
  - Loan agreement and related amortization schedule
  - Lease agreements

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Cost Report Form

- Required attachments to Filed Cost Reports
  - If related party management services:
    - Central office cost report
    - Central office allocation schedule
      - Including a description of the allocation basis used
    - Copy of contract or narrative description of contract services
  - If hospital based:
    - Hospital Medicare cost report worksheets A, A-6, A-7, A-8, A-8-1, B part I and B-1
    - Allocation worksheets

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Cost Report Form

- General Information
  - Cost report period must be for period July 1 – June 30
  - Cost report should be filed on or before the last day of September
    - If weekend or holiday, due the next business day
  - Any cost report submitted with missing documents, signatures, etc will be considered incomplete and will not satisfy the requirements for timely filing
  - If cost report is not submitted or not complete:
    - 5% penalty of total monthly payment for each month of non-compliance
    - Penalty may be progressive by 5% until all completed information is received

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Cost Report Form

- General Information
  - Extensions
    - Must be requested of DHH in writing AND must be received prior to cost report due date
    - Only for unavoidable difficulties
      - NO automatic extensions
    - Must include full statement of the cause

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Cost Report Form

- General Information
  - Non-filer Status
    - Transportation rate will be equal to the lowest allowable quarter hour transportation cost in the state
    - Other rate components will be based on state-wide medians
    - Direct care floor settlement will be based on the lowest direct care per diem of all facilities in the State

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Cost Report Form

- General Information
  - Use whole dollars
    - Only per diem amounts will not be rounded
  - Cost report line item titles (descriptions) should not be written over
  - "Miscellaneous" and "Other" line items require a detail or supplemental schedule to specify types of costs and amounts
  - Include cost allocation schedule(s) for all allocated costs (central office, hospital, etc.)

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Cost Report Form

- General Information
  - Accrual basis of accounting is required
    - if not used during the year, the information must be converted to accrual basis for cost report purposes
  - All records must be kept for at least 5 years
  - Complete all sections even if response is None, N/A, or $0

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Summary of Cost Report Schedules

- Schedule A – Facility Information
- Schedule B – Statistical Data
- Schedule C – Owner and Related Organization
- Schedule D – Staff and Other Information
- Schedule E – Staffing Pattern
- Schedule F – Balance Sheet
- Schedule G – Income Statement

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Summary of Cost Report Schedules

- Schedule H – Expenses
  - Parts A through E
- Schedule I – Explanation for Adjustments
- Schedule J – Costs Per Quarter Hour by Category
- Schedule K – Direct Care Cost Settlement
- Schedule L – Certification Statement

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Review of Cost Report

- Schedule B – Total client days available
  - should reflect any change in licensed capacity during the cost report period
  - should be based on the number of days the facility was open during the cost report period
- Schedule B – Report **ALL** days of attendance and **ALL** quarter hours regardless of payment source or non-payment
  - Must record days and quarter hours before Medicaid certification as other/private days and quarter hours

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Review of Cost Report

- Schedule C, Line 1 – Ownership Disclosure
  - Should include information regarding owners and relatives of owners employed by facility
  - For non-profit providers, this means listing officers/board of directors/key personnel and relatives who work for the facility (see HIM-15, Chapter 10)
  - Job descriptions and written documentation of time worked is required for the persons reported on Schedule C, line 1
  - Allowable compensation should be disclosed
  - All columns should be completed

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Review of Cost Report

- Schedule C, Line 2 – Changes in Ownership, Licensure or Certification
  - If applicable, all columns should be completed
- Schedule C, Line 3 – Lease Information
  - Disclose all facility and vehicle leases
  - Disclose if lessor is a related party

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Review of Cost Report

- Schedule C, Line 4 – Related Party Transactions
  - All transactions with a related party should be disclosed on Schedule C, line 4
    - Allocations from hospital or home office
    - Costs underlying related party leases
    - Goods or services obtained from businesses owned by owners and/or relatives
  - All columns should be completed
  - Related party transactions should be adjusted to allowable costs
    - See slides 47 thru 49 for further details

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Review of Cost Report

- Schedule D – Miscellaneous info
  - Line 4 – Select 4i. None if no benefits are provided
    - If any benefits are reported on the EB lines on Schedule H, then this section is required to be completed
    - Complete description for Lines 4f, 4g and 4h
  - Line 7 – Report rates received from private/insurance/other programs
    - Attach schedule if needed

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Review of Cost Report

- Schedule E - Staffing Pattern
  - Should report each position
    - Can have multiple persons filling one position
  - Actual salary for the CR period should agree to/reconcile to salaries reported on Schedule H, column a
  - Average hours per week should relate to salary reported
    - For example – an LPN who works full-time: hours per week would be 40
  - Complete all columns for all positions

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Review of Cost Report

- Schedule F – Balance Sheet
  - Enter amounts per year-end trial balance
  - Specify all other items in spaces provided
  - Line 30 should agree to Line 47

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Review of Cost Report

- Schedule G – Income Statement
  - Column “a” should agree to trial balance
  - Specify all other items in spaces provided
  - Adjustments to offset revenue should be reported on Schedule I
    - Offset adjustments must be reported on both Schedule G and Schedule H
  - Rules require all other income to be offset, exception donations
  - Grants – Must provide detail of grants
    - Can attach supplementary schedule

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Review of Cost Report

- Schedule H
  - Column “a” should agree to trial balance
  - Specify all other/miscellaneous accounts
    - Any costs described as “miscellaneous”, “other”, “various” without further detailed explanation will be automatically disallowed
    - Attach supplemental schedules, as needed, to describe any other/misc amounts. The sum of the amounts associated with each description should equal the amount reported on that cost report line

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Schedule H, Part A – Direct Care Costs

- Salaries and related costs for:
  - RNs, LPNs, Aides, Social Services, Activities
    - Excludes Activity Director
- Contract employees for the same positions
- Drugs – OTC & non-legend
- Medical waste disposal
- Allocated hospital direct care costs
- Medical, activity and other supplies

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Schedule H, Part A – Direct Care Costs

- Medical supplies – Line 14
  - Patient specific items
    - Catherers, syringes and sterile dressings
- Other direct care supplies – Line 16
  - Non-patient specific items
    - Recreational/activity supplies
    - Prep supplies
    - Alcohol pads, betadine, tongue depressors
    - Cotton balls
    - Thermometers and blood pressure cuffs

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Schedule H, Part B – Care Related Costs

- Salaries and related costs for:
  - Supervisory staff (nursing, social services & activities)
  - Dietary staff (dietary supervisors, cooks, helpers and dishwashers)
- Consultant Fees for:
  - Activities
  - Nursing
  - Pharmacy
  - Social Worker
  - Therapists
- Food & supplements
- Allocated hospital care related costs
- Supplies

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Schedule H, Part B – Care Related Costs

- Care related Supplies
  - Personal care items
    - Shampoo and soap
  - Excludes dietary supplies

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Schedule H, Part B – Care Related Costs (cont'd)

- Consultants
  - Consultant section of Schedule B (line 6a-6e) and Schedule C (line 15) should include those parties with whom a contractual relationship exists.
  - Should NOT include:
    - Routine medical care
    - Direct care services (i.e., contract employees)
    - Salaried personnel

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Schedule H, Part C – Admin. and Operating

- All other salary and related costs
  - Administrator(s), Housekeeping, Laundry, Maintenance, Other Admin, Owner
- Contract employees for same positions
- Consultant Dietician
- All other administrative, housekeeping, maintenance, laundry costs
- Dietary supplies
- Non-capital interest
- Management fees/Home office costs

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Schedule H, Part C – Admin. and Operating

- Accounting and legal fees
- Education seminars and training costs
- Insurance – Professional Liability
- Non-capital amortization
- Utilities
- Repairs & maintenance

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Schedule H, Part D – Property and Equipment

- Depreciation expense (excluding vehicles)
- Amortization – capital related
- Interest – capital related
  - Includes vehicles
- Property taxes
- Property insurance
- Vehicle insurance expense
- Rent
  - Building
  - Furniture and Equipment
- Allocated hospital capital costs

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Schedule H, Part E – Transportation

- Salaries and Wage - Drivers
- Non-emergency transportation
- Vehicles expenses (Gas, Oil, etc.)
- Depreciation expense – Motor Vehicles
- Auto lease

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Review of Cost Report

- Schedule I – Schedule of Adjustments
  - Should include explanations of adjustments, not just line item descriptions
    - For example: Correct – To offset misc. income
      Incorrect – Admin Misc expense
  - Software will post adjustments to Schedules G and H
    - All columns on Sch. I must be completed in order for software to work properly
  - Make sure to use a minus sign "-" in front of all negative adjustments

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Review of Cost Report

- Schedule J – Summary of Allowable Costs
  - No inputs required on this Schedule

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Schedule K – Direct Care Cost Settlement

- Lines 1a and 1b – Calculation of Direct Care Floor
  - Medicaid quarter hours X Direct care rate component (per DHH rate letter)
  - Times 70%
- Line 2 – Calculation of Medicaid Direct Care Allowable Costs
  - Medicaid Quarter Hours X Direct Care Costs/Day (from Sch J)
- Line 3 – Amount Due to State
- Inputs needed
  - Medicaid Quarter Hours
    - Must agree to total Medicaid quarter hours on Schedule B, Line 8a
    - Only one rate period in FY13
      - Use only line 1a

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Review of Cost Report

- Schedule M – Certification Page
  - Must be signed and sent with other attachments to the excel template
  - Check figures on signature page must agree to the excel template
- Validation edits
  - Follow-up on all errors prior to filing cost report

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Required Supporting Documentation

- Must be maintained for 5 years
- Includes financial and census records
  - Ledgers
  - Journal entries and support
  - Invoices
  - Vouchers
  - Cancelled checks
  - Time cards
  - Payroll journals
  - Support for allocations
  - Census records
- Must be adequate and available for audit

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Required Supporting Documentation

- Employee Time Records
  - Must be written
  - Can be sign-in sheets or time card
    - Must indicate date and hours worked
  - Must indicate job function for employees who perform multiple job functions
  - All employees even on a contract or consultant basis
  - Other requirements in SFP

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Required Supporting Documentation

- Billing Records
  - In accordance with recognized fiscal and accounting procedures
  - Individual records for each client
    - Must detail each charge and each payment
    - Must be current
    - Must itemize each entry
    - Must include date of payment and amount

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Basic Cost Principles

- Allowable cost
  - Reasonable
    - Expectation is that the provider seeks to minimize costs
    - Costs do not exceed what a prudent and cost conscious buyer would pay
    - Related to client care
  - Necessary and Proper
    - costs to develop and maintain the operation of client care facility and activities
    - costs which are common and accepted occurrences in field
- Generally accepted accounting principles (GAAP) are required (i.e., accrual basis of accounting)
  - Information sources are general ledger and census records

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Basic Cost Principles

- Costs related to other programs/businesses must be removed from allowable costs
  - Should not be reported on ADHC cost report at all if a separate GL is maintained for each program
  - If costs are combined in one GL, then provider should report all costs in col “a” on cost report and remove other program costs through adjustments in col “b”
  - Actual costs should be separated as transactions occur during the year
    - Coding of invoices to correct program
      - Including breakdown of invoice by program if purchasing is done as a group
    - Time sheets coded to correct program

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Basic Cost Principles

- Classification of costs
  - Invoices should be coded to the correct general ledger account when paid
  - If credit card statements are used for payment, the transactions on the statement must be also be coded to the correct general ledger account(s)
    - All monthly credit card transactions should be posted to the general ledger even if the balance is not paid in full (accrual basis)
    - Underlying receipts for each transaction on the credit card statement must be maintained to support the allowability of the costs

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Basic Cost Principles

- If personnel are shared among programs/ businesses, then appropriate cost allocation methods must be followed
  - Actual records
    - Time sheets that document time spent in each program
    - Payroll system that will post actual time based on time sheets
  - Time studies
    - Are allowed under federal rules
    - Very specific guidelines must be followed for time studies to be adequate substitute for actual time records

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Basic Cost Principles

- If an employee has two positions at the ADHC facility:
  - Time records should reflect time spent in each position
  - Payroll costs related to actual time spent in each position should be posted to payroll journals and be posted to the correct GL account each pay period
  - Allocation of costs can not be done retrospectively if time records were not kept during the cost report period
  - Time studies are allowable as a substitute for actual time spent but very specific guidelines must be followed
    - Also must be done throughout the cost report period

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Basic Cost Principles

- Related Party Transactions
  - Can be related through common ownership or common control
    - Ownership
      - Significant ownership or equity interest
    - Control
      - Key officers/board members
  - Exception
    - Transaction has to meet 4 criteria
  - See Chapter 10 of the PRM

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Basic Cost Principles

- Related Party Transactions
  - owner's salary
    - See slides 50 and 51
  - Salaries of other related parties
    - Must meet the same standards as owner's salary
  - rent/lease expense
    - Allowable to the extent of the underlying cost to the related party. Costs should be properly classified (i.e., depreciation should be reported on the depreciation line, interest on the interest line of the cost report, etc.)

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Basic Cost Principles

- Related Party Transactions
  - management fees
    - Related party management fees must be supported by a Medicaid cost report filed by the related party management company, accompanied by an appropriate allocation schedule. All related party management companies are subject to Medicaid audit.
  - interest
    - Related party interest is allowable to the extent of underlying interest expense incurred by the related party, and is subject to the rules regarding allowability of interest expense (see slide 54)
  - other

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Basic Cost Principles

- Owner's Compensation
- The Medicare Provider Reimbursement Manual (HIM-15), Chapter 9 addresses compensation of owners. The following briefly summarizes some HIM-15 principles for owner's compensation :
  - Owner's compensation means the total benefit received by the owner including salary, amounts paid for the owner's benefit by the facility, the cost of assets and services received from the facility by the owner, and deferred compensation.
  - Reasonableness requires that the owner's compensation be such an amount as would ordinarily be paid for comparable services and must be supported by sufficient documentation such as job descriptions and time sheets to be verifiable and auditable

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Basic Cost Principles

- Owner's Compensation
- Necessary requires that had the owner not furnished the services, the institution would have had to employ another person to perform the services.
- §904.2(D)(1) states, *"Presumably, where an owner performs services for several institutions, he spends less than full time with each institution. In such cases, allowable cost shall reflect an amount appropriate to a full-time basis."* Therefore, owners' compensation is limited to one full time equivalent position in the Louisiana Medical Assistance Program, no matter how many participating facilities the owner may have.
- In addition, owner's compensation is limited by the Bureau of Health Services Financing to the DHH compensation limit for administrators and assistant administrators. See DHH letter each year ($93,517 for 2013)

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Basic Cost Principles

- Depreciation expense
  - Should relate only to allowable assets
  - Should agree to depreciation expense reported on attached depreciation schedule
  - Asset useful lives must be follow AHA "Estimated Useful Lives of Hospital Assets"

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Basic Cost Principles

- Depreciation expense
  - Straight-line depreciation must be used
  - Expenditures must be capitalized if cost is at least $5,000 and the useful life is at least 2 years
  - Detail depreciation listing must reflect individual assets with specific description of asset, not vendor name

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Basic Cost Principles

- Interest is allowable if it is:
  - necessary for the operation of the facility & reasonably related to client care
  - proper - reasonable rate
  - interest expense should be reduced by interest income
  - related party interest is limited to underlying interest cost to related party

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General Non-allowable costs

- Any costs that are not reasonable
- Any costs not related to client care
- Services for which Medicaid recipients are charged a fee
- Services that are reimbursable by other state or federally funded program

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Specific Non-allowable costs

- Advertising that relates to efforts to increase client utilization
- Bad Debts
- Charitable contributions/donations
- Courtesy allowances
- Director's fees
- Educational cost for clients
- Gifts (including gifts to clients)
- Goodwill amortization
  - Interest used to finance purchase of goodwill

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Specific Non-allowable costs

- Income producing items
  - Fund raising costs
  - Promotional advertising
  - Public relations costs
- Income taxes
- Officers' life insurance
  - If the insurance is not provided to all employees
  - If Center or owner is beneficiary
- Judgments or settlements of any kind

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Specific Non-allowable costs

- Lobbying costs or political contributions
- Non-client entertainment
- Non-Medicaid related costs
  - Costs allocated to portions of the Center that are not licensed or are not certified to participate in Title XIX
- Payments to parent organization or other related party
- Penalties and sanctions
  - Assessed by CMS, IRS, State tax commission
  - NSF charges

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Specific Non-allowable costs

- Personal comfort items
- Personal use of vehicles
- Dues to more than one professional organization
- Salaries over the DHH limit
  - See DHH letter – $93,517
  - Must also adjust related payroll taxes and employee benefits
- Owner's and related party salary not supported by written time documentation
- Legal fees related to litigation

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Specific Non-allowable costs

- Start-up costs
  - Must be amortized over 60 months
- Leased or owned vehicles
  - Must have mileage logs if used for both personal and business
- Commuting expenses

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Income Offsets

- Purchase discounts, allowances, refunds and rebates
- Any income from sale of medical records, scrap or waste, rental of space, etc.
- Interest income
- Special purpose grants (ex., federal food/milk programs)
- Miscellaneous
- Rental income
- Any income with related expense

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Attendance Records

- Affirmative attendance records
  - Both days and quarter hours for all attendees are required to be reported on the cost report
  - Providers can use the LAST system to capture and report quarter hours for all payors (Medicaid, private, insurance, etc.)
    - Use “Clients without PA” to report quarter hours in LAST system
    - See example attached

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Attendance Records

- Affirmative attendance records
  - Should have a code for every day the facility is open
    - Blank days are not acceptable documentation
  - Should be performed and documented daily
  - Should be maintained by payor type
  - Should reflect monthly totals by client and by payor type
    - Totals should agree to client days and quarter hours reported on Schedule B
    - See example attached

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Attendance Records

- Census should be supported by:
  - Admission documents
  - Discharge summary/documents
  - Nurse’s notes/progress notes
  - Sign-in/out logs, etc.

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Attendance Records

- Payment is made for day of admission
- No payment is made for day of discharge
- Services can't exceed 10 hours/day, 50 hours/week
  - Documented in attendance records

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Attendance Records

- If a client has not attended for 30 consecutive calendar days, the client is no longer eligible
  - Exception – If the absence is due to hospitalization or nursing facility admission not to exceed 90 days

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Wrap Up

- Summary
- Questions
- Thanks!

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State of Louisiana
Department of Health and Hospitals
ADHC Cost Report

INSTRUCTIONS FOR FILING:

I **Within 90 days of cost report period end,** e-mail the following documentation to Myers and Stauffer.

Required Items (Must be submitted with your filing)
Note: Use numbering below to number your attachment files as indicated (e.g., the Central Office working trial balance would be numbered "8")

ADHC Documentation
1. Signed and dated Certification Page of the Louisiana Medicaid ADHC Cost Report
2. Electronic copy of completed Louisiana Medicaid ADHC cost report in Excel.
3. Grouping Schedule/Crosswalk that agrees to Schedules F, G, and H by cost report line item (must include general ledger accounts by account number and subtotal for each cost report line)
4. Detailed asset listing including full depreciation schedule as of the cost report period end.
5. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)

Central Office Documentation
6. Signed and dated Certification Page of the Louisiana Medicaid ADHC Central Office Cost Report.
7. Electronic copy of completed Louisiana Medicaid ADHC cost report in Excel.
8. Grouping Schedule/Crosswalk that agrees to Schedules F, G, and H by cost report line item (must include general ledger accounts by account number and subtotal for each cost report line)
9. Detailed asset listing including full depreciation schedule as of the cost report period end.
10. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)

II Electronic Files Should be Named in the following example formats (all files should be in .pdf except for the cost report which must be an Excel file):

Medicaid Cost Report File (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "Cost Report")
99999 CO group name - Facility name - 20090630 Cost Report.xls

If You Have One Attachment File(provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "CR Attachments")
99999 CO group name - Facility name - 20090630 CR Attachments.pdf

If You Have Multiple Attachment Files(provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + Description + Number Sequence from above list)
99999 CO group name - Facility name - 20090630 Depr Sched - 4.pdf
99999 CO group name - Facility name - 20090630 WTB - 3.pdf
etc…

All electronic documentation should be e-mailed to Myers and Stauffer at:
LAADHC@mslc.com

All paper documentation can be mailed (using certified or other traceable delivery) or faxed to:

Myers and Stauffer
ATTN: Louisiana ADHC
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211
Fax: (913) 234-1104
Phone: (800) 374-6858

III Make a back-up copy of your electronic cost report and retain for future reference.

Please Call Myers and Stauffer at 1-800-374-6858 if you have any questions on using the template or filing the cost report.

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

COST REPORT FOR ADULT DAY HEALTH CARE PROVIDERS

Schedule A - Facility Information

COST REPORT PERIOD: FROM: July 1, 2012 TO: June 30, 2013

DATE COMPLETED: 08/01/2013

CORPORATE NAME: NA

FACILITY NAME: ABC ADHC Center

MAILING ADDRESS:

MAILING ADDRESS: 123 Main Street

MAILING CITY: Baton Rouge STATE: LA ZIP: 70808 -

FACILITY ADDRESS:

STREET ADDRESS: 123 Main Street

CITY: Baton Rouge STATE: LA ZIP: 70808 -

CONTACT PERSON: John Smith PHONE: (225) 555-5555 EXT:

FAX: (225) 555-4444 EXT:

E-MAIL: mperoyea@pncpa.com

TYPE OF FACILITY

ADHC Vendor Number 12345

TYPE OF CONTROL (Select only one)

Nonprofit	Proprietary	Governmental
1. ○ Church Related	1. ○ Individual	1. ○ State
2. ◉ Private	2. ○ Partnership	2. ○ Parish
3. ○ Other (specify)	3. ○ Corporation	3. ○ City
		4. ○ City-Parish
		5. ○ Other (specify)

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE B - STATISTICAL DATA

1.	Licensed Capacity at Beginning of Cost Report Period		35
2.	Licensed Capacity at End of Cost Report Period		40
3.	Effective Date of Change in Licensed Capacity, if any		October 1, 2012
4.	Total Client Days Available	This is computed by multiplying the days the center is open times the licensed capacity	7,640
5.	Client Days at end of period *(a. + b. + c.)*		
	a. Medicaid Client Days	5,214	Lines 5a thru 5c should include all days regardless of payment source or non-payment
	b. Other State Client Days	0	
	c. Private Client Days	326	
6.	Total Client Days *(a. + b. + c.)*		5,540
7.	Occupancy Percent *(Line 6 divided by Line 4)*		72.51%
8.	Client Quarter Hours Paid and Payable at end of period *(a. + b. + c.)*		
	a. Medicaid Client Quarter Hour Increments	162,848	Lines 8a thru 8c should include all quarter hours regardless of payment source or non-payment
	b. Other State Client Quarter Hour Increments	0	
	c. Private Client Quarter Hour Increments	9,587	
9.	Total Client Quarter Hour Increments *(a. + b. + c.)*		172,435

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE C - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

1. List all owners with 5% interest or more (even if they receive no compensation) or Board of Directors and relatives of owners or Board of Directors employed by the provider.

Name	Function	% of Work Week Devoted to Business	% of Ownership	Compensation Included in Allowable Cost for This Period	
John Smith	Owner/Administrator	100.00%	50.00%	93,517	For profit disclosure example
Jane Smith	Owner/LPN	40.00%	25.00%	37,407	
Faye Smith	Owner	0.00%	25.00%	0	
John Smith	Board Chairman	100.00%	0.00%	93,517	Not for profit disclosure example
Jane Smith	Board Secretary	40.00%	0.00%	37,407	
Ray Jones	Board Treasurer	0.00%	0.00%	0	
Paul Williams	Board Member	0.00%	0.00%	0	

All columns for owners/key officers/board members must be completed. Put zero if applicable

All board members/key personnel should be listed for non-profit providers

Attachments are acceptable - Should address all 5 columns above

2. Changes in Ownership, Licensure, or Certification During Cost Report Period

Type of Change	From	To	Date of Change
Licensed capacity	35	40	10/1/2012

3. If the facility or any equipment is leased, give name(s) of owners(s) of leased asset(s), owner's relationship to the facility and terms of the lease. (Attach a copy of the executed lease agreements(s) effective during the cost report period).

Owner of Leased Assets	Relationship to Facility	Payments / Term	
John Smith	Owner	1000/mo	If building is owned by facility's owner
Nancy Williams	Sister of Board member	1000/mo	If building is owned by relative of Board member

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE C - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

4. In the amount of cost reported, are any costs included which are a result of transactions with related parties or organizations as defined in the Medicare Provider Reimbursement Manual (HIM-15)?

Yes — If "Yes", complete parts a. & b.

a. List costs incurred as a result of transactions with related parties or organizations.

Schedule H - Part	Line Item No. & Line Item Title	Amount Reported
D	2a. Depreciation - Buildings	3,500
D	4 Property Insurance	1,200
D	5 Property Taxes	600
D	3 Interest - Mortgage on Building or Equipment	2,100
D	6 Rent - Building	12,000
A	14 Medical Supplies	1,200

RP rent: Correct disclosure

RP rent: Incorrect disclosure

b. List name(s) of related parties or organizations and relationship to facility.

Name of Related Party	Name of Related Organizations	Relationship
John Smith	John Smith Real Estate	Owner
James Smith	Smith Medical Supply	brother of board member

Rent disclosure

Medical Supplies disclosure

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE D - STAFF AND OTHER INFORMATION

1. Total number of employees for last payroll: 15.0

2. Number of Minimum Wage Employees: 0.0

3. Position Summary — Full Time Equivalent

   a. Direct Care: 10.00

   b. Care Related: 1.00

   c. Administrative and Operating: 2.00

   Total Full Time Equivalent *(a. + b. + c.)*: 13.00

4. Fringe Benefits Provided

   a. ☐ Life Insurance

   b. ☑ Health Insurance

   c. ☑ Retirement Plan

   d. ☐ Uniforms

   e. ☐ Meals

   f. ☑ Other (Describe): Dental insurance

   g. ☐ Other (Describe):

   h. ☐ Other (Describe):

   i. ☐ None

Only use none if no employee benefits are reported on Sch H.

5. Number of vehicles owned or leased by facility: 0

6. Number of mortgages on fixed assets: 0

	Original Date	Amount	Interest Rate	Amortization Period
a. First Mortgage			NA	
b. Second Mortgage				
c. Third Mortgage				

7. Other rates received

   a. Private client rate: 125/day 4.00/qtr hr

   b. Other state or federal rates:

   c. Other *(specify)*:

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

Employee's salary exceeds DHH salary limit. Prov should make adjustment

SCHEDULE E - STAFFING PATTERN

Note: List each position separately.

Option 1 - Aides disclosure

Position Title	Avg Hours Per Week	Actual Salary for Cost Report Period	Schedule H (Part & Line Number)
Aides (6)	220.00	88,500	A-1
LPN	16.00	52,000	A-2
RN	8.00	10,000	A-3
Direct Care Supervisor	40.00	20,000	B-1
Cook	20.00	10,000	B-2
Administrator	40.00	100,000	C-1
Maintenance	15.00	6,000	C-5
Owner	0.00	15,000	C-7
Drivers	40.00	11,000	E-1

Reflects Part-time status

Option 2 - Aides disclosure

Direct care Aide	40.00	16,500	A-1
Direct care Aide	30.00	11,500	A-1
Direct care Aide	40.00	16,000	A-1
Direct care Aide	30.00	10,500	A-1
Direct care Aide	40.00	17,500	A-1
Direct care Aide	40.00	16,500	A-1

TOTAL **$ 401,000**

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE F - BALANCE SHEET

ASSETS

ACCOUNTS	PER BOOKS
Current Assets:	
1. Cash on Hand and in Banks	10,500
2. Accounts Receivable	34,000
3. Notes Receivable	
4. Other Receivables	
5. Less: Allowance for uncollectible Accounts Receivable & Notes Receivable	
6. Inventory	
7. Prepaid Expenses	250
8. Investment	
9. Other *(specify)* :	
10. Total Current Assets	$ 44,750
Fixed Assets:	
11. Land	
12. Buildings	
13. Less: Accumulated Depreciation	
14. Leasehold Improvements	12,000
15. Less: Accumulated Depreciation	(6,200)
16. Fixed Equipment	
17. Less: Accumulated Depreciation	
18. Major Movable Equipment	5,500
19. Less: Accumulated Depreciation	(1,250)
20. Motor Vehicles	71,000
21. Less: Accumulated Depreciation	(45,000)
22. Minor Equipment (non-depreciable)	
23. Total Fixed Assets	$ 36,050
Other Assets:	
24. Investments	
25. Deposits on Leases or Utilities	500
26. Due from Owners/Officers	
27. Dues to Funds	
28. Other *(specify)* :	
29. Total Other Assets	$ 500
30. TOTAL ASSETS *(sum of lines 10, 23 & 29)*	$ 81,300

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE F - BALANCE SHEET

LIABILITIES AND CAPITAL

ACCOUNTS		PER BOOKS
Current Liabilities		
31. Accounts Payable		42,000
32. Notes Payable		
33. Current Portion of Long-term Debt		7,000
34. Salaries-Fees Payable		4,000
35. Payroll Taxes Payable		400
36. Deferred Income		
37. Other *(specify)* :	Accrued Bonuses	1,200
38. Total Current Liabilities		$ 54,600
Long-Term Liabilities		
39. Mortgages Payable		
40. Notes Payable		15,000
41. Unsecured Loans		
42. Loans from Owners		
43. Total Long-Term Liabilities		$ 15,000
44. TOTAL LIABILITIES *(sum of lines 38 and 43)*		$ 69,600
45. Capital		
(a) Retained Earnings		
(b) Capital Stock		
(c) Other *(specify)*	Fund Balance	11,700
(d) Other *(specify)*		
(e) Other *(specify)*		
(f) Other *(specify)*		
(g) Other *(specify)*		
46. Total Capital		$ 11,700
47. TOTAL LIABILITIES AND CAPITAL *(sum of lines 44 and 46)*		$ 81,300

Adjustments in this column should have corresponding adjustment on Sch H

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
	Routine Service Income:			
1	Medicare - Routine		-	$ -
2	SSI/SSA - Routine		-	$ -
3a	Medicaid - State - Routine	456,000	-	$ 456,000
4	Other State Revenue - Routine		-	$ -
5	Private - Routine	38,000	-	$ 38,000
6a	Grants - Federal*		-	$ -
6b	Grants - State* Transportation	25,000	(6,250)	$ 18,750
7	Other *(specify)*		-	$ -
8	Total Routine Service Income	519,000	(6,250)	$ 512,750
	Other Income:			
9	Special expense reimbursement (state clients)		-	$ -
10a	Donations - Restricted		-	$ -
10b	Donations - Unrestricted	450	-	$ 450
11	Sale of Drugs		-	$ -
12	Therapy		-	$ -
13	Sale of Supplies		-	$ -
14	Employee and Guest Meals		-	$ -
15	Interest	25	(25)	$ -
16	Rentals		-	$ -
17	Beauty and Barber Shop		-	$ -
18	Vending Machine		-	$ -
19a	Miscellaneous *(specify)* Workers' comp refund	600	(600)	$ -
19b	Miscellaneous *(specify)*		-	$ -
19c	Miscellaneous *(specify)*		-	$ -
19d	Miscellaneous *(specify)*		-	$ -

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
19e	Miscellaneous *(specify)*		-	$ -
20	Total Other Income	1,075	(625)	$ 450
21	Total Income *(line 8 and 20)*	520,075	(6,875)	$ 513,200
	Less Refunds and Allowances**			
22	Medicare - Refunds an Allowances		-	$ -
23	SSI/SSA - Refunds and Allowances		-	$ -
24	Medicaid - Refunds and Allowances		-	$ -
25	Other State Revenue - Refunds and Allowances		-	$ -
26	Private - Refunds and Allowances		-	$ -
27	Other *(specify)*		-	$ -
28	Total Refunds and Allowances	-	-	$ -
29	Net Income *(line 21 minus 28)*	520,075	(6,875)	$ 513,200

*State type grant, period covered; if more than one, provide separate listing.
If grant is continuous or declining, state percentages or amounts.

**Indicate amount reimbursed or credited to DHH (if any).

Column a should agree to the cost report grouping schedule attached to the cost report

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
A. Direct Care Costs				
1 Salaries - Aides		88,500	-	$ 88,500
2 Salaries - LPNs		52,000	(14,593)	$ 37,407
3 Salaries - RNs		10,000	-	$ 10,000
4 Salaries - Social Services			-	$ -
5 Salaries - Activities (excl. Act. Dir.)			-	$ -
6 Payroll Taxes		12,700	(1,231)	$ 11,469
7 Employee Benefits		14,000	(1,357)	$ 12,643
8 Workers' Compensation		2,200	(294)	$ 1,906
9 Contract - Aides			-	$ -
10 Contract - LPNs			-	$ -
11 Contract - RNs			-	$ -
12 Contract - Social Services (MSW)		12,000	-	$ 12,000
13 Drugs - OTC & Non-Legend		350	-	$ 350
14 Medical Supplies		1,400	-	$ 1,400
15 Medical Waste Disposal			-	$ -
16 a. Recreation/Activity Supplies		2,300	-	$ 2,300
b. Other Supplies (specify)			-	$ -
17 Allocated Costs - Hospital Based			-	$ -
18 a. Miscellaneous (specify)			-	$ -
b. Miscellaneous (specify)			-	$ -
Total Direct Care Costs		**$ 195,450**	**$ (17,475)**	**$ 177,975**

Should not include salaried personnel

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
B. Care Related Costs				
1 Salaries - Supervisory Staff		20,000	-	$ 20,000
2 Salaries - Dietary		10,000	-	$ 10,000
3 Payroll Taxes		2,500	-	$ 2,500
4 Employee Benefits		5,200	-	$ 5,200
5 Workers' Compensation		700	(93)	$ 607
6 Consultant Fees				
a. Activities Consultant Fees	Not contract employees		-	$ -
b. Nursing Consultant Fees			-	$ -
c. Pharmacy Consultant Fees			-	$ -
d. Social Worker Consultant Fees			-	$ -
e. Therapists Consultant Fees			-	$ -
7 Food-Raw		8,000	-	$ 8,000
8 Food-Supplements			-	$ -
9 Supplies		1,500	-	$ 1,500
10 Allocated Costs - Hospital Based			-	$ -
11 Miscellaneous				
a. Miscellaneous (specify)	*Hygeine supplies*	150	-	$ 150
b. Miscellaneous (specify)			-	$ -
Total Care Related Costs		**$ 48,050**	**$ (93)**	**$ 47,957**

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE H - EXPENSES

Expense Classification	(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
C. Administrative and Operating Costs			
1 Salaries and Wages - Administrator	100,000	(6,483)	$ 93,517
2 Salaries and Wages - Asst Administrator		-	$ -
3 Salaries and Wages - Housekeeping		-	$ -
4 Salaries and Wages - Laundry		-	$ -
5 Salaries and Wages - Maintenance	6,000	-	$ 6,000
6 Salaries and Wages - Other Administrative		-	$ -
7 Salaries and Wages - Owner or Owner/Admin.	15,000	(15,000)	$ -
8 Payroll Taxes	11,500	(2,042)	$ 9,458
9 Employee Benefits	14,500	(2,575)	$ 11,925
10 Workers' Compensation	1,600	(213)	$ 1,387
11 Contract - Dietary		-	$ -
12 Contract - Housekeeping		-	$ -
13 Contract - Laundry		-	$ -
14 Contract - Maintenance		-	$ -
15 Consultant Fees - Dietician	3,000	-	$ 3,000
Administrative & Operating Subtotal	$ 151,600	$ (26,313)	$ 125,287

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
16 Accounting Fees		4,000	-	$ 4,000
17 Amortization Expense Non-Capital			-	$ -
18 Bank Service Charge		1,200	-	$ 1,200
19 Board of Directors' Fees		5,000	(5,000)	
20 Dietary Supplies		1,800	-	$ 1,800
21 Dues		600	-	$ 600
22 Educational Seminars and Training		1,100	-	$ 1,100
23 Housekeeping Supplies		650	-	$ 650
24 Insurance - Professional Liability and Other		2,800	-	$ 2,800
25 Interest on Non-Capital and Vehicles		3,200	(25)	$ 3,175
26 Laundry Supplies			-	$ -
27 Legal Fees		400	-	$ 400
28 Linen Supplies			-	$ -
29 Management Fees and Home Office Costs			-	$ -
30 Office Supplies and Subscriptions		2,200	-	$ 2,200
31 Postage		120	-	$ 120
32 Repairs and Maintenance		9,800	-	$ 9,800
33 Taxes and License		1,600	-	$ 1,600
34 Telephone & Communications		7,600	-	$ 7,600
35 Travel			-	$ -
36 Utilities		4,500	-	$ 4,500
37 Allocated Costs - Hospital Based			-	$ -
38 Maintenance Supplies		690	-	$ 690
39 Advertising		3,600	(2,500)	$ 1,100
40 Miscellaneous				
a. Miscellaneous (specify)	*Donations*	1,000	(1,000)	$ -
b. Miscellaneous (specify)	*Christmas tree/decorations*	150	-	$ 150
c. Miscellaneous (specify)	*Background checks*	320	-	$ 320
d. Miscellaneous (specify)			-	$ -
e. Miscellaneous (specify)			-	$ -
Total Administrative and Operating Costs		**$ 203,930**	**$ (34,838)**	**$ 169,092**

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE H - EXPENSES

Expense Classification	(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
D. Property and Equipment			
1 Amortization Expense - Capital		-	$ -
2 Depreciation Expense - (Provide detailed schedules)			
a. Depreciation - Buildings		3,500	$ 3,500
b. Depreciation - Furniture & Equipment	630	-	$ 630
c. Depreciation - Leasehold Improvements	700	-	$ 700
3 Interest Expense - Capital		2,100	$ 2,100
4 Property Insurance		1,200	$ 1,200
5 Property Taxes		600	$ 600
6 Rent - Building	12,000	(12,000)	$ -
7 Rent - Furniture & Equipment		-	$ -
8 Allocated Costs - Hospital		-	$ -
9 Miscellaneous			
a. Miscellaneous (specify)		-	$ -
b. Miscellaneous (specify)		-	$ -
Total Property & Equipment	**$ 13,330**	**$ (4,600)**	**$ 8,730**
E. Transportaton Expense			
1 Salaries and Wages - Drivers	11,000	-	$ 11,000
2 Non-Emergency Medical Transportation		-	$ -
3 Vehicle Expenses (Gas, Oil, etc..)	14,500	-	$ 14,500
4 Depreciation - Motor Vehicles	10,250	(6,250)	$ 4,000
5 Auto Lease		-	$ -
Total Transportation Expense	**$ 35,750**	**$ (6,250)**	**$ 29,500**
Sum of Sections A, B, C, D, and E	**$ 496,510**	**$ (63,256)**	**$ 433,254**

Explanation should reflect the reason for the adjustment, not just the account title

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment
1	G - Income Stmt		15 Interest	Total	To offset interest income	(25)
1	H - Expenses	C	25 Interest on Non-Capital and Vehicles	Total	To offset interest income	(25)
2	G - Income Stmt		19a Miscellaneous (specify)	Total	To offset worker's comp refund	(600)
2	H - Expenses	A	8 Workers' Compensation	Total	To offset worker's comp refund	(294)
2	H - Expenses	B	5 Workers' Compensation	Total	To offset worker's comp refund	(93)
2	H - Expenses	C	10 Workers' Compensation	Total	To offset worker's comp refund	(213)
3	H - Expenses	A	2 Salaries - LPNs	Total	To adjust salary to DHH salary limit	(14,593)
3	H - Expenses	A	6 Payroll Taxes	Total	To adjust payroll taxes related to salary limit adjustment	(1,231)
3	H - Expenses	A	7 Employee Benefits	Total	To adjust employee benefits related to salary limit adjustment	(1,357)
4	H - Expenses	C	1 Salaries and Wages - Administrator	Total	To adjust administrator salary to DHH salary limit	(6,483)
4	H - Expenses	C	8 Payroll Taxes	Total	To adjust payroll taxes related to administrator's salary limit adjustment	(616)
4	H - Expenses	C	9 Employee Benefits	Total	To adjust employee benefits related to administrator's salary adjustment	(777)
5	H - Expenses	C	7 Salaries and Wages - Owner or Owner/Admin.	Total	To remove unsupported owner's salary	(15,000)
5	H - Expenses	C	8 Payroll Taxes	Total	To remove payroll taxes related to unsupported owner's salary	(1,426)
5	H - Expenses	C	9 Employee Benefits	Total	To remove employee benefits related to unsupported owner's salary	(1,798)
6	H - Expenses	C	19 Board of Directors' Fees	Total	To remove board of directors fees	(5,000)
7	H - Expenses	C	39 Advertising	Total	To remove promotional advertising	(2,500)
8	H - Expenses	C	40a. Miscellaneous	Total	To remove donations	(1,000)
9	H - Expenses	D	2a. Depreciation - Buildings	Total	To add actual building expense incurred by related party	3,500

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment
9	H - Expenses	D	3 Interest - Mortgage on Building or Equipment	Total	To add actual building expense incurred by related party	2,100
9	H - Expenses	D	4 Property Insurance	Total	To add actual building expense incurred by related party	1,200
9	H - Expenses	D	5 Property Taxes	Total	To add actual building expense incurred by related party	600
9	H - Expenses	D	6 Rent - Building	Total	To remove related party lease expense	(12,000)
10	G - Income Stmt		6b Grants - State*	Total	To offset transportation grant income	(6,250)
10	H - Expenses	E	4 Depreciation - Motor Vehicles	Total	To offset transportation grant income	(6,250)

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment

INCOME TOTALS	**(6,875)**
EXPENSE TOTALS	**(63,256)**
GRAND TOTALS (Includes Statistics)	**(70,131)**

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE J - SUBMITTED CALCULATION OF COSTS PER QUARTER HOUR BY CATEGORY

Expense Classification	Allowable Expenses (a)	Divided by Total Client Quarter Hour Increments (b)	Allowable Cost per Quarter Hour Increment (c)
A. Direct Care Costs	177,975 (from Schedule H, Part A, Total)	172,435 (from Sched. B, #6 Total)	$ 1.03 (Column a Divided by b)
B. Care Related Costs	47,957 (from Schedule H, Part B, Total)	172,435 (from Sched. B, #6 Total)	$ 0.28 (Column a Divided by b)
C. Administrative and Operating Costs	169,092 (from Schedule H, Part C, Total)	172,435 (from Sched. B, #6 Total)	$ 0.98 (Column a Divided by b)
D. Property & Equipment	8,730 (from Schedule H, Part D, Total)	172,435 (from Sched. B, #6 Total)	$ 0.05 (Column a Divided by b)
E. Transportation Costs	29,500 (from Schedule H, Part E, Total)	172,435 (from Sched. B, #6 Total)	$ 0.17 (Column a Divided by b)

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE K - Direct Care Cost Settlement

Provider's As-Submitted Data

		(a) Medicaid Quarter Hour Increments		(b) Direct Care Rate Component		(c) Medicaid Direct Care Revenue	(d) Medicaid Direct Care Revenue 70%
1a.	7/1/2012 - 6/30/2013	162,848	x	$ 1.27	=	$ 206,817	$ 144,772
1b.	n/a - n/a		x	$ -	=	$ -	$ -
		162,848				$ 206,817	$ 144,772

		(a) Medicaid Quarter Hour Increments		(b) Direct Care Costs Per Quarter Hour Increment		(c) Medicaid Direct Care Allowable Cost
2.	Actual Cost	162,848	x	$ 1.03	=	$ 167,733
3.	Due to State	Subtract Line 2, Col. (c) from Line 1, Col. (d) (if less than zero, enter zero)				$ -

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

SCHEDULE M - Certification Statement by Owner, Officer, or Administrator of Facility

I, John Smith (Name), Administrator (Administrative Title)

of ABC ADHC Center (Name of Facility)

Baton Rouge (City), LA (State) do certify that I have examined the attached report for the cost report period beginning 7/1/2012 and ending 6/30/2013 and to the best of my knowledge and belief, it is a true and correct statement of the information required.

Signature of Authorized Representative of Facility — Date: 8/1/2013

Title: Administrator

Total ADHC Quarter Hour Increments:	172,435	Total Medicaid Direct Care Revenue:	$ 206,817
Total Allowable Expenses:	$ 433,254	Amount Due To State	$ -

Comments:

Signature of Preparer — Date

Name of Preparer

VENDOR NUMBER: 12345
FACILITY NAME: ABC ADHC Center
COST REPORT PERIOD: 7/1/2012 TO 6/30/2013

Validation Edits

Comparison #1		Comparison #2		Difference
Total Assets	$ 81,300	Total Liabilities & Capital	$ 81,300	$ -
(Sched. F - Balance Sheet, Line 30)		*(Sched. F - Balance Sheet, Line 47)*		
Total Client Days	5,540	Total Client Days Available	7,640	
(Sched. B - Stats, Line 6)		*(Sched. B - Stats, Line 4)*		
Director's Fees Amount	$ 5,000	Director's Fees Adjustment Amount	$ (5,000)	$ 10,000
(Sched. H - Expenses, Pt. C, Line 19, Column a)		*(Sched. H - Expenses, Pt. C, Line 19, Columns b & c)*		
Total Client Adjustments Posted	$ (70,131)	Total Client Adjustments Entered	$ (70,131)	$ -
Total DHH Adjustments Posted	$ -	Total DHH Adjustments Entered	$ -	$ -
Schedule A Properly Completed				
Schedule B Properly Completed				
Schedule C Properly Completed				
Schedule D Properly Completed				

**Amounts in Difference column should be zero.

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Louisiana ADHC Cost Report Template Instructions

ADHC Version 2.7 7/01/13

For Versions of Excel prior to 2007, there is a toolbar that includes buttons for Auditor, Add Row, Delete Extra Rows, Print, and Instructions that should show above, if the macros have been properly enabled.

For Office 2007 (new version), Auditor, Add Row, Delete Extra Rows, Print, and Instructions toolbar buttons will show under the "Add-Ins" menu if the macros have been properly enabled.

Macro Security Change Instructions (needed to run template with macros enabled)

For Microsoft Excel 2007:

You can change macro security settings in the Trust Center, unless a system administrator in your organization has changed the default settings to prevent you from changing the settings.

On the **Developer** tab, in the **Code** group, click **Macro Security**.

Tip If the **Developer** tab is not displayed, click the **Microsoft Office Button** (upper left hand corner of the screen), click **Excel Options,** and then in the **Popular category,** under **Top options** for working with Excel, click **Show Developer tab in the Ribbon.**

In the **Macro Settings** category, under **Macro Settings**, click the option that enables all macros (low security) or the option

that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message above the formula bar - you must click the Options… button to enable the macros after you open the file).

For Older Versions of Microsoft Excel:

Click **"Tools"** on the Menu and then click **"Macro" – "Security"**. Select **"Low" or "Medium"** security. Then reopen the cost report template file.

General

Custom Toolbar Buttons:

Auditor Toolbar Button - for use by P&N only.
Add and Delete Extra Rows - used on adjustment report schedule, related parties, and staffing schedules.
Print - used to print package.
Instructions - used to access this page.

All lines and schedules should be completed by the provider. If the appropriate answer is zero or not applicable, the provider must report "0" or "NA". No lines should be left blank.

All dollar amounts should be rounded to the nearest dollar. Only per diem amounts reported on Schedules D and K. should include cents. All per diems should be rounded to the nearest penny.

All costs reported on the cost report should be in accordance with the Louisiana ADHC Standards for Payment and the Federal CMS Publication 15. The accrual basis of accounting is required. Amount per books should be adjusted to the accrual basis prior to completion of the cost report. The cost report should reflect all year-end closing entries.

To access the CMS Publication 15 go to the following web-site:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

Use the TAB key to move throughout the forms to ensure no fields are skipped. Use drop-down arrows to scroll and select items in fields that contain lists.

Schedule A - Facility Info

Identifying Information

Report in the spaces provided the corporate and facility name, address, also mailing address if different from street address, Title XIX vendor number and accounting period. The name and telephone number of a contact person should be specified.

Type of Control

Check one appropriate block.

Schedule B - Stats

Statistical and Other Data

1. Enter total number of licensed capacity at beginning of the period.

2. Enter total number of licensed capacity at end of the period.

3. Enter effective date of change in licensed capacity, if applicable.

4. Enter client days available (licensed capacity times days the facility was open for the period.

5. Enter the client days (including hospital leave days) in the appropriate category.

6. Enter the client quarter hour increments in the appropriate category. (Example: 0.25 hours = 1 quarter hour increment)

Schedule C - Related Parties

Ownership and Related Organization

1. List all owners or board of directors and relatives of owners or board of directors employed by the facility.

2. If changes in ownership, licensure, or certification occurred during the report period, enter the changed information (from -- to) and date of each change.

3. If facility is leased or rented, give name of owner of each leased asset, relationship to the facility, and terms of the lease. A copy of lease or rental agreements in effect during the report period must be attached to the cost report.

4. If the facility has related party transactions as defined in the HIM-15, complete a. and b.

Schedule D - Misc

Staff and Other Information

1. Indicate total number of employees for the last payroll in the period.

2. Indicate number of minimum wage employees

3. For each category, indicate the full time equivalent (total hours divided by 40). Indicate total full time equivalent.

4. Benefits provided employees -- check each type of benefits provided for one or more employees. Describe any other benefits provided.

5. Number of vehicles owned or leased by facility - Enter the number of cars, trucks, vans, and station wagons owned or leased by the facility. Do not include boats, airplanes, etc.

6. Number of mortgages on fixed assets - enter number. Indicate original date, amount, and interest rate on each - enter date, amount, and interest rate for first, second, and third mortgage.

7. Indicate other non-Medicaid rates received.

Schedule E - Staffing

Staffing Pattern

Complete staffing pattern for each position and indicate line item number.

Schedule F - Balance Sheet

Balance Sheet-Assets
Enter appropriate balance sheet asset accounts per books as of the end of the cost report period.

Balance Sheet-Liabilities
Enter appropriate balance sheet liability and equity accounts per books as of the end of the cost report period.

Schedule G - Income Statement

Income Statement

Enter appropriate income account balances per books as of the end of the period.

Schedule H - Expenses

Part A, Direct Care Costs

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line A, column (a).

Part B, Care Related Costs

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line B, column (a).

Part C, Administrative and Operating Costs

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total Column (c) to page 16, Line C, column (a).

Part D, Property and Equipment

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line D, column (a).

A copy of the depreciation schedule must be attached for each line item reporting depreciation expense.

Part E, Transportation Costs

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line E, column (a).

A copy of the depreciation schedule must be attached for each line item reporting depreciation expense.

Schedule I - Adjustments

Schedule of Adjustments

Enter the information for each adjustment on these pages.

Schedule J - Cost Per Quarter Hour

Calculation of Costs Per Quarter Hour Increment by Category

Divide Column (a) (Allowable Expenses) by Column (b) (Total client quarter hour increments reported on page 2.) to calculate Column (c) Cost Per Quarter Hour Increment for each category. Enter the sum of Lines A., B., C., D., and E. in column (c) for Total Cost per Quarter Hour Increment.

Schedule K - Settlement

Direct Care Cost Settlement

1. Multiply the Direct Care Rate Component (Column (b)) by the number of Medicaid Quarter Hour Increments Column (a) (reported on page 2, 8., a.) to calculate Direct Care Revenue Column (c). Multiply Medicaid Direct Care Revenue Column (c) by 70%, enter amount in Column (d). This amount is used for the cost settlement calculation.

2. Multiply Medicaid Quarter Hour Increments Column (a) (days reported on page 2, 8., a.) times the Direct Care cost per Quarter Hour Increment from Line A, Column (c), page 16 to calculate Medicaid Direct Care Allowable Costs, enter in Column (c). Subtract line 2., (c) from line 1., (d) to calculate the amount Due to State.

3. Enter amount Due to State. (If amount is less than "0", enter "0".)

If calculation shows money due the Department of Health and Hospitals DO NOT remit payment with the cost report. Provider will be notified of amount due after the Desk Review / Audit.

Schedule L - Depreciation
Schedule No Longer Filed - Submit detailed asset listing with the cost report.

Schedule M - Certification

Certification Statement

This page must be completed, signed (original signature – no stamps) and dated by the Representative of the facility and the person preparing the cost report.

Follow the filing instructions on the cover page of the cost report.

To receive official reimbursement notices and software releases, please email LAADHC@mslc.com
and include the name of the template and your name.

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identification, as well as other requested information, to the Louisiana Board of Examiners for Speech-Language Pathology and Audiology for registration with this agency prior to gratuitously providing audiology or speech-language pathology services in Louisiana.

6. Should a qualified audiologist, speech-language pathologist, or speech-language pathology assistant registered with the board thereafter fail to comply with any requirement or condition established by this Section, the board may terminate his registration upon notice and hearing.

7. In the event an audiologist, speech-language pathologist, or speech-language pathology assistant fails to register with the board, but practices audiology or speech-language pathology, whether gratuitously or otherwise, then such conduct will be considered the unlawful practice of audiology or speech-language pathology and prosecuted accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2650 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners for Speech-Language Pathology and Audiology, LR 14:707 (October 1988), amended LR 22:352 (May 1996), LR 27:199 (February 2001), LR 28:1974 (September 2002), LR 30:2311 (October 2004), LR 33:2193 (October 2007), LR 37:2393 (August 2011), repromulgated LR 37:2623 (September 2011).

§131. Hearing Aid Dispensing

A. - F.1.b. …

c. a basic audiological test battery conducted in a soundtreated environment within the preceding six month period, including:

i. pure tone air and bone conduction testing;

ii. speech reception threshold;

iii. word recognition testing;

iv. appropriate tolerance testing;

v. Repealed;

d. middle ear measurements shall also be obtained when indicated.

2. - 3. …

4. Audiologists shall conduct a post-fitting evaluation that includes functional gain measurements conducted in a soundtreated environment and/or real ear measurements unless the patient's physical conditions~~-~~ prohibit accomplishment of these procedures.

F.5. - H.2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2650 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners for Speech-Language Pathology and Audiology, LR 22:353 (May 1996), amended LR 27:201 (February 2001), LR 28:1975 (September 2002), LR 30:2317 (October 2004), LR 33:2198 (October 2007), LR 37:2398 (August 2011), repromulgated LR 37:2624 (September 2011).

Emily Efferson
Administrator

1109#024

RULE

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care (LAC 50:XXI.2103, 2107, 2301, 2501, 2503, 2701, 2901-2905, and 2915)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.2103, §2107, §2301, §2501, §2503, §2701, §2901-2905, and §2915 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care

Chapter 21. General Provisions

§2103. Program Description

A. An Adult Day Health Care Waiver Program expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities. This program provides direct care for individuals who have physical, mental or functional impairments. ADHC waiver participants must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. Exceptions for extenuating circumstances must be approved by the assigned support coordinator based upon guidance provided by OAAS.

B. - C.6. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011).

§2107. Programmatic Allocation of Waiver Opportunities

A. …

B. Adult day health care waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for ADHC waiver opportunities in the order listed:

1. individuals with substantiated cases of abuse or neglect with Adult Protective Services (APS) or Elderly Protective Services (EPS) and who, absent ADHC waiver

services, would require institutional placement to prevent further abuse and neglect;

a. - c. Repealed.

2. individuals who have been discharged after a hospitalization within the past 30 days that involved a stay of at least one night;

3. individuals presently residing in nursing facilities for 90 or more continuous days; and

4. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

C. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified and the process continues until an individual is determined eligible. An ADHC waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

D. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011).

Chapter 23. Services

§2301. Covered Services

A. …

1. Adult Day Health Care. ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. An adult day health care center shall, at a minimum, furnish the following services:

a. - j. …

NOTE: Repealed.

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the recipient's approved plan of care (POC). This is a mandatory service.

A.3. - B. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011).

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. - 3. …

4. reasonable assurance that the health and welfare of the individual can be maintained in the community with the provision of ADHC Waiver services.

B. Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria in this Section will result in denial of admission to the ADHC Waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2040 (September 2004), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011).

§2503. Denial and Discharge Criteria

A. Admission shall be denied or the recipient shall be discharged from the ADHC Waiver Program if any of the following conditions are determined.

1. - 7. …

8. The participant fails to attend the ADHC center for a minimum of 36 days per calendar quarter.

9. The individual fails to maintain a safe home environment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011).

Chapter 27. Provider Participation

§2701. General Provisions

A. - B. …

C. ADHC providers shall ensure that all non-licensed direct care staff meet the minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179 - 2179.1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011).

Chapter 29. Reimbursement

§2901. General Provisions

A. Development. Adult day health care providers shall be reimbursed a per quarter hour rate for services provided under a prospective payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all adult day health care waiver recipients by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2041 (September 2004), amended by

the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2257 (December 2006), LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011).

§2903. Cost Reporting

A. Cost Centers Components

1. - 3.e. …

4. Property. This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes and other expenses related to capital assets, excluding property cost related to patient transportation.

5. Transportation. This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance and supply expense, and automotive expenses related to ADHC patient transportation.

B. - L.2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011).

§2905. Cost Categories Included in the Cost Report

A. - B.19. …

C. Administrative and Operating Costs (AOC)

1. - 5. …

6. Salaries, Other Administrative—gross salaries of other administrative personnel including bookkeepers, receptionists, administrative assistants and other office and clerical personnel.

7. Salaries, Owner or Owner/Administrator—gross salaries of all owners of the center that are paid through the center.

8. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for administrative and operating employees.

9. Group Insurance, AOC—cost of employer's contribution to employee health, life, accident and disability insurance for administrative and operating employees.

10. Pensions, AOC—cost of employer's contribution to employee pensions for administration and operating employees.

11. Uniform Allowance, AOC—employer's cost of uniform allowance and/or uniforms for administration and operating employees.

12. Worker's Compensation, AOC—cost of worker's compensation insurance for administration and operating employees.

13. Contract, Housekeeping—cost of housekeeping services and personnel hired through contract that are not employees of the center.

14. Contract, Laundry—cost of laundry services and personnel hired through contract that are not employees of the center.

15. Contract, Maintenance—cost of maintenance services and persons hired through contract that are not employees of the center.

16. Consultant Fees, Dietician—fees paid to consulting registered dieticians.

17. Accounting Fees—fees incurred for the preparation of the cost report, audits of financial records, bookkeeping, tax return preparation of the adult day health care center and other related services excluding personal tax planning and personal tax return preparation.

18. Amortization Expense, Non-Capital—costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of 60 months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are nonallowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

19. Bank Service Charges—fees paid to banks for service charges, excluding penalties and insufficient funds charges.

20. Dietary Supplies—costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc., used in the dietary department.

21. Dues—dues to one organization are allowable.

22. Educational Seminars and Training—the registration cost for attending educational seminars and training by employees of the center and costs incurred in the provision of in-house training for center staff, excluding owners or administrative personnel.

23. Housekeeping Supplies—cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

24. Insurance, Professional Liability and Other—includes the costs of insuring the center against injury and malpractice claims.

25. Interest Expense, Non-Capital and Vehicles—interest paid on short term borrowing for center operations.

26. Laundry Supplies—cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to patient care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, gowns, under-pads and diapers (reusable and disposable).

29. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expense are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, allowable advertising, and flowers purchased for the enjoyment of the clients. Items reported on this line must be specifically identified.

30. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule.

31. Office Supplies and Subscriptions—cost of consumable goods used in the business office such as:

a. pencils, paper and computer supplies;

b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

32. Postage—cost of postage, including stamps, metered postage, freight charges and courier services.

33. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

34. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line on Form 6. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

35. Telephone and Communications—cost of telephone services, wats lines and fax services.

36. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

37. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

38. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

39. Total Administrative and Operating Costs.

D. Property and Equipment

1. - 7. …

8. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital or state institution as property costs when those costs include allocated overhead.

9. Total Property and Equipment.

E. Transportation Costs

1. Salaries, Drivers—gross salaries of personnel involved in transporting clients to and from the center.

2. Non-Emergency Medical Transportation—the cost of purchased non-emergency medical transportation services including, but not limited to:

a. payments to employees for use of personal vehicle;

b. ambulance companies; and

c. other transportation companies for transporting patients of the center.

3. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

4. Lease, Automotive—cost of leases for vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both patient care and personal purposes, cost must be allocated based on the mileage log.

5. Total Transportation Costs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2166 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011).

§2915. Provider Reimbursement

A. Cost Determination Definitions

* * *

Base Rate Components—the base rate is the summation of the following:

a. direct care;

b. care related costs;

c. administrative and operating costs;

d. property costs; and

e. transportation costs.

* * *

B. Rate Determination

1. - 5. …

6. Allowable quarter hours are used to calculate the per quarter hour costs for each of the rate components. Allowable quarter hours are calculated using the following criteria:

a. a maximum daily reimbursement limit of 10 hours per participant day;

b. reimbursement will be for full quarter hour (15 minute) increments only; and

c. the quarter hour data used in rate setting shall be from the database of hours provided by the department.

7. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the Consumer Price Index-Medical Services (South Region) Index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated median.

i.-ii. Repealed.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by the value of the Consumer Price Index-All Items (South Region) Index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-All Items (South Region) Index for December of the year preceding the base rate year

by the value of the index for the December of the year preceding the cost report year. The administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider's transportation cost will be reimbursed as follows:

i. New provider, as described in §2915.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that gave gone through a change of ownership (CHOW), as described in §2915.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §2915.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost in the state as of the most recent audited and/or desk reviewed rate database.

8. Budgetary Constraint Rate Adjustment. Effective July 1, 2011, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

9. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of five percent or more, the rate may be changed. The department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. Temporary adjustments do not affect the base rate used to calculate new rates.

i. Changes Reflected in the Economic Indices. Temporary adjustments may be made when changes which will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate change, occur after the end of the period covered by the indices, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

ii. Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to the bureau's review and approval of costs prior to reimbursement.

b. Base Rate Adjustment. A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

10. Provider Specific Adjustment. When services required by these provisions are not made available to the recipient by the provider, the department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the department that the provider last provided the service and shall remain in effect until the department validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database trended forward to the rate period related to the disclaimer.

D. Support Coordination Services Reimbursement. Support coordination services previously provided by ADHC providers and included in the rate, including the minimum data set home care (MDS/HC), the social assessment, the nursing assessment, the CPOC and home visits will no longer be the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the ADHC waiver. As a result of the change in responsibilities, the rate paid to ADHC providers shall be adjusted accordingly.

1. - 2. Repealed.

E. New Facilities, Changes of Ownership of Existing Facilities, and Existing Facilities with Disclaimer or Non-Filer Status

1. New facilities are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New facilities will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §2915.B.1-7. These new facilities will also receive the state-wide average transportation rate component, as calculated in §2915.B.7.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures in this rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §2903, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §2915.B.1-7. The transportation component will be reimbursed as described in §2915.B.7.e.iii.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2627 (September 2011).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Bruce D. Greenstein
Secretary

1109#054

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Federally Qualified Health Centers
Diabetes Self-Management Training
(LAC 50:XI.Chapters 103-105 and 10701)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XI.Chapters 103-105 and §10701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 13. Federally-Qualified Health Centers
Chapter 103. Services

§10301. Scope of Services
[Formerly 10501]

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician within the scope of practice of his profession under Louisiana law;

2. services furnished by a:
   a. physician assistant;
   b. nurse practitioner;
   c. nurse midwife;
   d. clinical social worker;
   e. clinical psychologist; or
   f. dentist;

3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals;

4. other ambulatory services; and

5. diabetes self-management training (DSMT) services.

B. Effective February 20, 2011, the department shall provide coverage of diabetes self-management training services rendered to Medicaid recipients diagnosed with diabetes.

1. The services shall be comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011).

§10303. Service Limits
[Formerly 10503]

A. Federally qualified health center visits (encounters) are limited to 12 visits per year for medically necessary services rendered to Medicaid recipients who are 21 years of age or older. Visits for Medicaid recipients who are under 21 years of age and for prenatal postpartum care are excluded from the service limitation.

B. Recipients of DSMT services shall receive up to 10 hours of services during the first 12-month period beginning with the initial training date.

1. After the first 12-month period has ended, recipients shall only be eligible for two hours of individual instruction on diabetes self-management per calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2280 (October 2010), amended by the

9. has fully completed required application form with all supporting data and certification of competency and good character;

10. if deemed necessary, has appeared for a personal interview before the board;

11. has submitted two recent passport type color photographs;

12. has all units of time accounted for;

13. has provided true copy of diploma(s) and/or national board examination grades and transcript of dental hygiene school grades;

14. has furnished three current letters of recommendation from professional associates, i.e., associations, boards, or prior employers listed on application for licensure on letterhead stationery from said organization;

15. possesses a current certificate in Cardiopulmonary Resuscitation Course "C", Basic Life Support for Health Care Providers as defined by the American Heart Association or the Red Cross Professional Rescue Course;

16. is a citizen or permanent resident of the United States unless otherwise prohibited by the North American Free Trade Agreement;

17. is free of any communicable or contagious disease, including but not limited to Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus, and provide a notarized certificate of health from a medical doctor relative to his/her physical and mental condition;

18. has completed continuing education equivalent to the state of Louisiana's for the two years prior to applying for licensure by credentials.

B. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:760(8) and R. S. 37:768.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 18:737 (July 1992), amended LR 21:570 (June 1995), LR 22:23 (January 1996), LR 24:1117 (June 1998), LR 25:513 (March 1999), LR 26:692 (April 2000), LR 26:1613 (August 2000), repromulgated LR 27:1894 (November 2001), amended LR 28:1778 (August 2002), LR 33:846 (May 2007); LR 33:2652 (December 2007), LR 34:2564 (December 2008).

§1709. Examination of Dentists

A. - B.4 ...

C. To be licensed as a dentist in this state, an applicant must successfully complete the clinical licensing examination as administered by the Council of Interstate Testing Agencies (CITA), Central Regional Dental Testing Service (CRDTS), Northeast Regional Board (NERB), Southern Regional Testing Agency (SRTA), or American Dental Examination (ADEX).

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(1) and (8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 24:1119 (June 1998), amended LR 28:2513 (December 2002), LR 33:2654 (December 2007), LR 34:2565 (December 2008).

§1711. Examination of Dental Hygienists

A. - C.1. ...

2. a practical or clinical examination as administered by the Council of Interstate Testing Agencies (CITA), Central Regional Dental Testing Service (CRDTS), Northeast Regional Board (NERB), Southern Regional Testing Agency (SRTA), or American Dental Examination (ADEX), which shall test the competency of the applicant's ability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(1) and (8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 24:1119 (June 1998), amended LR 28:1779 (August 2002), LR 33:2654 (December 2007), LR 34:2565 (December 2008).

C. Barry Ogden
Executive Director

0812#006

RULE

Department of Health and Hospitals
Office of Aging and Adult Services

Home and Community Based Services Waivers
Adult Day Health Care
(LAC 50:XXI.Chapters 21-39)

Editor's Note: This Rule is being repromulgated because of an error upon submission. The original Rule can be viewed in its entirety on page 2161 of the October 20, 2008 *Louisiana Register*.

The Department of Health and Hospitals, Office of Aging and Adult Services has amended LAC 50:XXI.Chapters 21-39 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 3. Adult Day Health Care

Chapter 21. General Provisions

§2101. Introduction

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Waiver Program. The program is funded as a waived service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health and Hospitals (DHH).

B. Waiver services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

C. Any provider of services under the ADHC Waiver shall abide by and adhere to any federal or state laws, rules or any policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008).

§2103. Program Description

A. An adult day health care waiver program expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities. This program provides direct care for five or more hours a day (not to exceed five days per week) to individuals who have physical, mental or functional impairments.

B. The target population for the ADHC Waiver Program includes individuals who:

1. are 65 years old or older; or

2. 22 to 64 years old and with a disability according to Medicaid standards or the Social Security Administration's disability criteria; and

3. meet nursing facility level of care requirements.

C. The long-range goal for all adult day health care participants is the delay or prevention of long-term care facility placement. The more immediate goals of the adult day health care waiver are to:

1. promote the individual's maximum level of independence;

a. - f. Repealed.

2. maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration;

3. restore and rehabilitate the individual to the highest possible level of functioning;

4. provide support and education for families and other caregivers;

5. foster socialization and peer interaction; and

6. serve as an integral part of the community services network and the long-term care continuum of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008).

§2105. Definitions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2256 (December 2006), repealed LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008).

§2105. Request for Services Registry (Formerly §2107)

A. The Department of Health and Hospitals is responsible for the Request for Services Registry, hereafter referred to as "the registry", for the adult day health care waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll free telephone number which shall be maintained by the department.

B. Individuals who desire their name to be placed on the ADHC Waiver registry shall be screened by the department, or its designee, to determine whether they meet nursing facility level of care. Only individuals who meet this criterion will be added to the registry.

C. - D. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2256 (December 2006), LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008).

§2107. Programmatic Allocation of Waiver Opportunities

A. When funding is appropriated for a new ADHC Waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. That individual shall be evaluated for a possible ADHC Waiver opportunity assignment.

B. Adult day health care waiver opportunities shall be offered based upon the date of first request for services, with priority given to individuals who are in nursing facilities but could return to their home if ADHC Waiver services are provided. Priority shall also be given to those individuals who have indicated that they are at imminent risk of nursing facility placement.

1. A person is considered to be at imminent risk of nursing facility placement when he:

a. is likely to require admission to a nursing facility within the next 120 days;

b. faces a substantial possibility of deterioration in mental condition, physical condition or functioning if either home and community-based services or nursing facility services are not provided within 120 days; or

c. has a primary caregiver who has a disability or is age 70 or older.

C. Remaining waiver opportunities, if any, shall be offered on a first-come, first-serve basis to individuals who qualify for nursing facility level of care, but who are not at imminent risk of nursing facility placement.

D. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified and the process continues until an individual is determined eligible. An ADHC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008).

Chapter 23. Services

§2301. Covered Services

A. The following services are available to recipients in the ADHC Waiver. All services must be provided in accordance with the approved comprehensive plan of care (CPOC). No services shall be provided until the CPOC has been approved.

1. Adult Day Health Care. ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished for five or more hours per day (exclusive of transportation time to and from the ADHC center) on a regularly scheduled basis for one or more days per week (not to exceed five days per week), or as specified in the

individualized service plan. An adult day health care center shall, at a minimum, furnish the following services:

a. individualized training or assistance with the activities of daily living (toileting, grooming, eating, ambulation, etc.);

b. health and nutrition counseling;

c. an individualized, daily exercise program;

d. an individualized, goal directed recreation program;

e. daily health education;

f. medical care management;

g. one nutritionally-balanced hot meal and two snacks served each day;

h. nursing services that include the following individualized health services;

i. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;

ii. administering medications and treatments in accordance with physicians' orders;

iii. monitoring self-administration of medications while the recipient is at the ADHC center;

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

i. transportation to and from the center at the beginning and end of the program day; and

j. transportation to and from medical and social activities when the participant is accompanied by center staff;

NOTE: If transportation services that are prescribed in any individual's approved ISP are not provided by the ADHC center, the center's reimbursement rate shall be reduced accordingly.

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for these services. This is a mandatory service.

3. Transition Intensive Support Coordination. These services will assist participants currently residing in nursing facilities who want to transition into the community. These services assist participants in gaining access to needed medical, social, educational and other services, regardless of the funding source for these services.

4. Transition Service. These services that will assist an individual transition from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses.

5. Other Services. ADHC providers may provide other services and activities as identified in the current ADHC provider manual that enhance the participant's independence and community involvement.

B. An individual must require and maintain the need for two waiver services.

C. - I.5. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008).

§2303. Individualized Service Plan

A. All ADHC services shall:

1. be provided according to the individualized service plan;

2. be a result of an interdisciplinary staffing in which the participant and direct care staff participate;

3. be written in terminology which all center personnel can understand;

4. list the identified problems and needs of the participant for which intervention is indicated as identified in assessments, progress notes and medical reports;

5. propose a reasonable, measurable short-term goal for each problem/need;

6. contain the necessary elements of the center's self administration of medication plan, if applicable;

7. use the strengths of the participant in developing approaches to problems;

8. specify the approaches to be used for each problem and that each approach is appropriate to effect positive change for that problem;

9. identify the staff member responsible for carrying out each approach;

10. project the resolution date or review date for each problem;

11. specify the frequency of each approach/service;

12. contain a sufficient explanation of why the participant would require 24-hour care were he/she not receiving ADHC services;

a. - b. Repealed.

13. include the number of days and time of scheduled attendance each week;

14. include discharge as a goal; and

15. be kept in the participant's record used by direct care staff.

A.16 - D.12. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2567 (December 2008).

§2305. Medical Certification Application Process

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2038 (September 2004), repromulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2257 (December 2006), repealed LR 34:2163 (October 2008), repromulgated LR 34:2567 (December 2008).

§2307. Interdisciplinary Team

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2039 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2567 (December 2008).

§2309. Interdisciplinary Team Assessments

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2039 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2257 (December 2006), repealed LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

§2311. Staffings

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2040 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

§2313. Plan of Care

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2040 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

§2315. Progress Notes

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2040 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. initial and continued Medicaid financial eligibility;

2. initial and continued eligibility for a nursing facility level of care;

3. justification, as documented in the approved CPOC, that the ADHC Waiver services are appropriate, cost-effective and represent the least restrictive environment for the individual; and

4. assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC Waiver services.

B. Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria in §2501.A above will result in denial of admission to the ADHC Waiver.

C. - D.13. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2040 (September 2004), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

§2503. Denial or Discharge Criteria

A. Admission shall be denied or the recipient shall be discharged from the ADHC Waiver Program if any of the following conditions are determined.

1. The individual does not meet the criteria for Medicaid financial eligibility.

2. The individual does not meet the criteria for a nursing facility level of care.

3. The recipient resides in another state or has a change of residence to another state.

4. Continuity of services is interrupted as a result of the recipient not receiving and/or refusing ADHC Waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

5. The health, safety and welfare of the individual cannot be assured through the provision of ADHC Waiver services.

6. The individual fails to cooperate in the eligibility determination process or in the performance of the CPOC.

7. It is not cost effective to serve the individual in the ADHC Waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008).

Chapter 27. Provider Participation

§2701. General Provisions

A. Each adult day health care center shall enter into a provider agreement with the department to provide services which may be reimbursed by the Medicaid program, and shall agree to comply with the provisions of this Rule.

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions.

C. ADHC providers shall ensure that all non-licensed direct care staff meet the minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-2179.1 and be registered on the Louisiana Direct Service Worker Registry.

D. - G. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008).

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to report changes to the department that could affect the waiver recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordinators and direct service providers, including ADHC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the recipient and completing an

incident report. The incident report shall be submitted to the department with the specified requirements.

C. Support coordinators shall provide the participant's approved comprehensive plan of care to the ADHC provider in a timely manner.

D. ADHC providers shall provide the participant's approved individualized service plan to the support coordinator in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008).

Chapter 29. Reimbursement

§2901. General Provisions

A. Development. Adult Day Health Care providers shall be reimbursed a per diem rate for services provided under a prospective payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all adult day health care waiver recipients by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. Reimbursement shall not be made for ADHC Waiver services provided prior to the department's approval of the CPOC.

C. - E.1. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2257 (December 2006), LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008).

§2903. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for activity and social services staff, raw food costs and care related supplies for activities and social services.

3. Administrative and Operating Costs. This component reimburses for in-house or contractual salaries and related benefits for administrative, dietary, housekeeping and maintenance staff. Also included are:

a. utilities;

b. accounting;

c. dietary;

d. housekeeping and maintenance supplies; and

e. all other administrative and operating type expenditures.

4. Property. This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes and other expenses related to capital assets.

B. Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date reports are submitted to the bureau. A chart of accounts and an accounting system on the accrual basis or converted to the accrual basis at year end are required in the cost report preparation process. The bureau or its designee will perform desk reviews of the cost reports. In addition to the desk review, a representative number of the facilities shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

C. The cost reporting forms and instructions developed by the bureau must be used by all ADHC facilities participating in the Louisiana Medicaid Program. Hospital based and other provider based ADHC which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms also. All amounts must be rounded to the nearest dollar and must foot and cross foot. Only per diem cost amounts will not be rounded. Cost reports submitted that have not been rounded in accordance with this policy will be returned and will not be considered as received until they are resubmitted.

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and schedules must be filed in duplicate together with two copies of the following documents:

1. a working trial balance that includes the appropriate cost report line numbers to which each account can be traced. This may be done by writing the cost report category and line numbers by each ending balance or by running a trial balance in cost report category and line number order that totals the account;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital based facilities must submit two copies of a depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets;

3. an amortization schedule(s), if applicable;

4. a schedule of adjustment and reclassification entries;

5. a narrative description of purchased management services and a copy of contracts for managed services, if applicable;

6. For management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule; and

7. all allocation worksheets must be submitted by hospital-based facilities. The Medicare worksheets that must

be attached by facilities using the Medicare forms for allocation are:

a. A;
b. A-6;
c. A-7 parts I, II and III;
d. A-8;
e. A-8-1;
f. B part 1; and
g. B-1.

E. Each copy of the cost report must have the original signatures of an officer or center administrator on the certification. The cost report and related documents must be submitted to the address indicated on the cost report instruction form. In order to avoid a penalty for delinquency, cost reports must be postmarked on or before the due date.

F. When it is determined, upon initial review for completeness, that an incomplete or improperly completed cost report has been submitted, the provider will be notified. The provider will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports that are submitted by the due date, 10 working days from the date of the provider's receipt of the request for additional information will be allowed for the submission of the additional information. For cost reports that are submitted after the due date, five working days from the date of the provider's receipt of the request for additional information will be allowed for the submission of the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. If requested additional information has not been submitted by the specified date, a second request for the information will be made. Requested information not received after the second request may not be subsequently submitted and shall not be considered for reimbursement purposes. An appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses for which requested information is not submitted.

G. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for the equitable distribution of costs to the applicable period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the reporting period.

H. Supporting Information. Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. Financial and statistical records must be maintained by the center for five years from the date the cost report is submitted to the bureau. Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, bases for apportioning costs, etc.) that pertain to the reported costs. Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing.

I. Employee Record

1. The provider shall retain written verification of hours worked by individual employees.

a. Records may be sign-in sheets or time cards, but shall indicate the date and hours worked.

b. Records shall include all employees even on a contractual or consultant basis.

2. Verification of criminal background check.

3. Verification of employee orientation and in-service training.

4. Verification of the employee's communicable disease screening.

J. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each client. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the client.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

K. Non-Acceptable Descriptions. "Miscellaneous", "other" and "various", without further detailed explanation, are not acceptable descriptions for cost reporting purposes. If any of these are used as descriptions in the cost report, a request for information will not be made and the related line item expense will be automatically disallowed. The provider will not be allowed to submit the proper detail of the expense at a later date, and an appeal of the disallowance of the costs may not be made.

L. Exceptions. Limited exceptions to the cost report filing requirements will be considered on an individual provider basis upon written request from the provider to the Bureau of Health Services Financing, Rate and Audit Review Section. If an exception is allowed, the provider must attach a statement describing fully the nature of the exception for which prior written permission was requested and granted. Exceptions which may be allowed with written approval are as follows.

1. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. If the center experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain a full statement of the cause of the difficulties that rendered timely preparation of the cost report impossible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008).

§2905. Cost Categories Included in the Cost Report

A. Direct Care (DC) Costs

1. Salaries, Aides-gross salaries of certified nurse aides and nurse aides in training.

2. Salaries, LPNs-gross salaries of nonsupervisory licensed practical nurses and graduate practical nurses.

3. Salaries, RNs-gross salaries of nonsupervisory registered nurses and graduate nurses (excluding director of nursing and resident assessment instrument coordinator).

4. Salaries, Social Services-gross salaries of nonsupervisory licensed social services personnel providing medically needed social services to attain or maintain the highest practicable physical, mental, or psychosocial well being of the residents.

5. Salaries, Activities—gross salaries of nonsupervisory activities/recreational personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well being of the residents.

6. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for direct care employees.

7. Group Insurance, DC—cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.

8. Pensions, DC—cost of employer's contribution to employee pensions for direct care employees.

9. Uniform Allowance, DC—employer's cost of uniform allowance and/or uniforms for direct care employees.

10. Worker's Comp, DC—cost of worker's compensation insurance for direct care employees.

11. Contract, Aides—cost of aides through contract that are not center employees.

12. Contract, LPNs—cost of LPNs and graduate practical nurses hired through contract that are not center employees.

13. Contract, RNs—cost of RNs and graduate nurses hired through contract that are not center employees.

14. Drugs, Over-the-Counter and Legend—cost of over-the-counter and legend drugs provided by the center to its residents. This is for drugs not covered by Medicaid.

15. Medical Supplies—cost of patient-specific items of medical supplies such as catheters, syringes and sterile dressings.

16. Medical Waste Disposal—cost of medical waste disposal including storage containers and disposal costs.

17. Other Supplies, DC—cost of items used in the direct care of residents which are not patient-specific such as recreational/activity supplies, prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, and blood pressure cuffs.

18. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

19. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) Costs

1. Salaries—gross salaries for care related supervisory staff including supervisors or directors over nursing, social service and activities/recreation.

2. Salaries, Dietary—gross salaries of kitchen personnel including dietary supervisors, cooks, helpers and dishwashers.

3. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for care related employees.

4. Group Insurance, CR—cost of employer's contribution to employee health, life, accident and disability insurance for care related employees.

5. Pensions, CR—cost of employer's contribution to employee pensions for care related employees.

6. Uniform Allowance, CR—employer's cost of uniform allowance and/or uniforms for care related employees.

7. Worker's Comp, CR—cost of worker's compensation insurance for care related employees.

8. Barber and Beauty Expense—the cost of barber and beauty services provided to patients for which no charges are made.

9. Consultant Fees, Activities—fees paid to activities personnel, not on the center's payroll, for providing advisory and educational services to the center.

10. Consultant Fees, Nursing—fees paid to nursing personnel, not on the center's payroll, for providing advisory and educational services to the center.

11. Consultant Fees, Pharmacy—fees paid to a registered pharmacist, not on the center's payroll, for providing advisory and educational services to the center.

12. Consultant Fees, Social Worker—fees paid to a social worker, not on the center's payroll, for providing advisory and educational services to the center.

13. Consultant Fees, Therapists—fees paid to a licensed therapist, not on the center's payroll, for providing advisory and educational services to the center.

14. Food, Raw—cost of food products used to provide meals and snacks to residents. Hospital based facilities must allocate food based on the number of meals served.

15. Food, Supplements—cost of food products given in addition to normal meals and snacks under a doctor's orders. Hospital based facilities must allocate food-supplements based on the number of meals served.

16. Supplies, CR—the costs of supplies used for rendering care related services to the patients of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

17. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as care related costs when those costs include allocated overhead.

18. Total Care Related Costs—the sum of the care related cost line items.

19. Contract, Dietary—cost of dietary services and personnel hired through contract that are not employees of the center.

C. Administrative and Operating Costs (AOC)

1. Salaries, Administrator—gross salary of administrators excluding owners. Hospital based facilities must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing center.

2. Salaries, Assistant Administrator—gross salary of assistant administrators excluding owners.

3. Salaries, Housekeeping—gross salaries of housekeeping personnel including housekeeping supervisors, maids and janitors.

4. Salaries, Laundry—gross salaries of laundry personnel.

5. Salaries, Maintenance—gross salaries of personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineers.

6. Salaries, Drivers—gross salaries of personnel involved in transporting clients to and from the center.

7. Salaries, Other Administrative—gross salaries of other administrative personnel including bookkeepers, receptionists, administrative assistants and other office and clerical personnel.

8. Salaries, Owner or Owner/Administrator—gross salaries of all owners of the center that are paid through the center.

9. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for administrative and operating employees.

10. Group Insurance, AOC—cost of employer's contribution to employee health, life, accident and disability insurance for administrative and operating employees.

11. Pensions, AOC—cost of employer's contribution to employee pensions for administration and operating employees.

12. Uniform Allowance, AOC—employer's cost of uniform allowance and/or uniforms for administration and operating employees.

13. Worker's Compensation, AOC—cost of worker's compensation insurance for administration and operating employees.

14. Contract, Housekeeping—cost of housekeeping services and personnel hired through contract that are not employees of the center.

15. Contract, Laundry—cost of laundry services and personnel hired through contract that are not employees of the center.

16. Contract, Maintenance—cost of maintenance services and persons hired through contract that are not employees of the center.

17. Consultant Fees, Dietician—fees paid to consulting registered dieticians.

18. Accounting Fees—fees incurred for the preparation of the cost report, audits of financial records, bookkeeping, tax return preparation of the adult day health care center and other related services excluding personal tax planning and personal tax return preparation.

19. Amortization Expense, Non-Capital—costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of 60 months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are nonallowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

20. Bank Service Charges—fees paid to banks for service charges, excluding penalties and insufficient funds charges.

21. Dietary Supplies—costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc., used in the dietary department.

22. Dues—dues to one organization are allowable.

23. Educational Seminars and Training—the registration cost for attending educational seminars and training by employees of the center and costs incurred in the provision of in-house training for center staff, excluding owners or administrative personnel.

24. Housekeeping Supplies—cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

25. Insurance, Professional Liability and Other—includes the costs of insuring the center against injury and malpractice claims.

26. Interest Expense, Non-Capital and Vehicles—interest paid on short term borrowing for center operations.

27. Laundry Supplies—cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

28. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to patient care are allowed.

29. Linen Supplies—cost of sheets, blankets, pillows, gowns, under-pads and diapers (reusable and disposable).

30. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expense are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, allowable advertising, and flowers purchased for the enjoyment of the clients. Items reported on this line must be specifically identified.

31. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule.

32. Nonemergency Medical Transportation—the cost of purchased nonemergency medical transportation services including, but not limited to, payments to employees for use of personal vehicle, ambulance companies and other transportation companies for transporting patients of the center.

33. Office Supplies and Subscriptions—cost of consumable goods used in the business office such as:

a. pencils, paper and computer supplies;

b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

34. Postage—cost of postage, including stamps, metered postage, freight charges and courier services.

35. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

36. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line on Form 6. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

37. Telephone and Communications—cost of telephone services, wats lines and fax services.

38. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

39. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

40. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

41. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

42. Total Administrative and Operating Costs

D. Property and Equipment

1. Amortization Expense, Capital—legal and other costs incurred when financing the center must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are nonallowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

2. Depreciation—depreciation on the center's buildings, furniture, equipment, leasehold improvements and land improvements.

3. Interest Expense, Capital—interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the center's land, buildings and/or furniture, equipment and vehicles.

4. Property Insurance—cost of fire and casualty insurance on center buildings, equipment and vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

5. Property Taxes—taxes levied on the center's buildings, equipment and vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

6. Rent, Building—cost of leasing the center's real property.

7. Rent, Furniture and Equipment—cost of leasing the center's furniture and equipment, excluding vehicles.

8. Lease, Automotive—cost of leases for vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both patient care and personal purposes, cost must be allocated based on the mileage log.

9. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital or state institution as property costs when those costs include allocated overhead.

10. Total Property and Equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2166 (October 2008), repromulgated LR 34:2571 (December 2008).

§2907. Allowable Costs

A. Allowable costs include those costs incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

1. These general cost principles include determining whether the cost is:

a. ordinary, necessary, and related to the delivery of care;

b. what a prudent and cost conscious business person would pay for the specific goods or services in the open market or in an arm's length transaction; and

c. for goods or services actually provided to the center.

B. Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider's reported costs. The Medicare Provider Reimbursement Manual is the final authority for allowable costs unless the department has set a more restrictive policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2168 (October 2008), repromulgated LR 34:2573 (December 2008).

§2909. Nonallowable Costs

A. Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of recipients are considered nonallowable costs.

B. Reasonable cost does not include the following:

1. costs not related to client care;

2. costs specifically not reimbursed under the program;

3. costs that flow from the provision of luxury items or services (items or services substantially in excess or more expensive than those generally considered necessary for the provision of the care);

4. costs that are found to be substantially out of line with other centers that are similar in size, scope of services and other relevant factors;

5. costs exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

C. General nonallowable costs:

1. services for which Medicaid recipients are charged a fee;

2. depreciation of non-client care assets;

3. services that are reimbursable by other state or federally funded programs;

4. goods or services unrelated to client care;

5. unreasonable costs.

D. Specific nonallowable costs (this is not an all inclusive listing):

1. advertising—costs of advertising to the general public that seeks to increase patient utilization of the ADHC center;

2. bad debts—accounts receivable that are written off as not collectible;

3. contributions—amounts donated to charitable or other organizations;

4. courtesy allowances;

5. director's fees;

6. educational costs for clients;

7. gifts;

8. goodwill or interest (debt service) on goodwill;

9. costs of income producing items such as fund raising costs, promotional advertising, or public relations costs and other income producing items;

10. income taxes, state and federal taxes on net income levied or expected to be levied by the federal or state government;

11. insurance, officers—cost of insurance on officers and key employees of the center when the insurance is not provided to all employees;

12. judgments or settlements of any kind;

13. lobbying costs or political contributions, either directly or through a trade organization;

14. non-client entertainment;

15. non-Medicaid related care costs—costs allocated to portions of a center that are not licensed as the reporting ADHC or are not certified to participate in Title XIX;

16. officers' life insurance with the center or owner as beneficiary;

17. payments to the parent organization or other related party;

18. penalties and sanctions—penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, the Internal Revenue Service or the State Tax Commission; insufficient funds charges;

19. personal comfort items; and

20. personal use of vehicles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2573 (December 2008).

§2911. Audits

A. Each provider shall file an annual center cost report and, if applicable, a central office cost report.

B. The provider shall be subject to financial and compliance audits.

C. All providers who elect to participate in the Medicaid program shall be subject to audit by state or federal regulators or their designees. Audit selection shall be at the discretion of the department.

1. The department conducts desk reviews of all of the cost reports received and also conducts on-site audits of provider cost reports.

2. The records necessary to verify information submitted to the department on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to the department's audit staff.

D. In addition to the adjustments made during desk reviews and on-site audits, the department may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

E. The center shall retain such records or files as required by the department and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

F. If a center's audit results in repeat findings and adjustments, the department may:

1. withhold vendor payments until the center submits documentation that the non-compliance has been resolved;

2. exclude the provider's cost from the database used for rate setting purposes; and

3. impose civil monetary penalties until the center submits documentation that the non-compliance has been resolved.

G. If the department's auditors determine that a center's financial and/or census records are unauditable, the vendor payments may be withheld until the center submits auditable records. The provider shall be responsible for costs incurred by the department’s auditors when additional services or procedures are performed to complete the audit.

H. Vendor payments may also be withheld under the following conditions:

1. a center fails to submit corrective action plans in response to financial and compliance audit findings within 15 days after receiving the notification letter from the department; or

2. a center fails to respond satisfactorily to the department's request for information within 15 days after receiving the department's notification letter.

I. The provider shall cooperate with the audit process by:

1. promptly providing all documents needed for review;

2. providing adequate space for uninterrupted review of records;

3. making persons responsible for center records and cost report preparation available during the audit;

4. arranging for all pertinent personnel to attend the closing conference;

5. insuring that complete information is maintained in client’s records;

6. developing a plan of correction for areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2574 (December 2008).

§2913. Exclusions from the Database

A. The following providers shall be excluded from the database used to calculate the rates:

1. providers with disclaimed audits; and

2. providers with cost reports for periods other than a 12-month period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2574 (December 2008).

§2915. Provider Reimbursement

A. Cost Determination Definitions

Adjustment Factor—computed by dividing the value of the index for December of the year preceding the rate year by the value of the index one year earlier (December of the second preceding year).

Base Rate—calculated in accordance with §2915.B.5, plus any base rate adjustments granted in accordance with §2915.B.7 which are in effect at the time of calculation of new rates or adjustments.

Base Rate Components—the base rate is the summation of the following:

a. direct care;
b. care related costs;
c. administrative and operating costs; and
d. property costs.

Indices—

a. CPI, All Items—the Consumer Price Index for All Urban Consumers-South Region (All Items line) as published by the United States Department of Labor.

b. CPI, Medical Services—the Consumer Price Index for All Urban Consumers-South Region (Medical Services line) as published by the United States Department of Labor.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports.

2. Audited and desk reviewed costs for each component are ranked by center to determine the value of each component at the median.

3. The median costs for each component are multiplied in accordance with §2915.B.4 then by the appropriate economic adjustment factors for each successive year to determine base rate components. For subsequent years, the components thus computed become the base rate components to be multiplied by the appropriate economic adjustment factors, unless they are adjusted as provided in §2915.B.7 below. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made prorating allocated funds based on the weight of the rate components.

4. The inflated median shall be increased to establish the base rate median component as follows.

a. The inflated direct care median shall be multiplied times 115 percent to establish the direct care base rate component.

b. The inflated care related median shall be multiplied times 105 percent to establish the care related base rate component.

c. The administrative and operating median shall be multiplied times 105 percent to establish the administrative and operating base rate component.

5. At least every three years, audited and desk reviewed cost report items will be compared to the rate components calculated for the cost report year to insure that the rates remain reasonably related to costs.

6. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care per diem costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward using the Consumer Price Index for Medical Services. The direct care rate component shall be set at 115 percent of the inflated median.

i. For dates of service on or after February 9, 2007, and extending until the ADHC rate is rebased using a cost report that begins after 7/1/2007, the center-specific direct care rate will be increased by $1.11 to include a direct care service worker wage enhancement. It is the intent that this wage enhancement be paid to the direct care service workers.

b. Care Related Cost Component. Care related per diem costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward using the Consumer Price Index for All Items. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating per diem cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-All Items index for December of the year proceeding the base rate year by the value of the index for the December of the year preceding the cost report year. The administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property per diem costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

7. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of five percent or more, the rate may be changed. The department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. Temporary adjustments do not affect the base rate used to calculate new rates.

i. Changes Reflected in the Economic Indices. Temporary adjustments may be made when changes which will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate change, occur after the end of the period covered by the indices, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

ii. Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to the Bureau's review and approval of costs prior to reimbursement.

b. Base Rate Adjustment. A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

8. Provider Specific Adjustment. When services required by these provisions are not made available to the recipient by the provider, the department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the department that the provider last provided the service and shall remain in effect until the department validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 90 percent of the median direct care rate component trended forward for direct care services (plus 90 percent of any direct care incentive added to the rate). The Medicaid program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database trended forward to the rate period related to the disclaimer.

D. Support Coordination Services Reimbursement. Support coordination services previously provided by ADHC providers and included in the rate, including the Minimum Data Set Home Care (MDS/HC), the social assessment, the nursing assessment, the CPOC and home visits will no longer be the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the ADHC Waiver. As a result of the change in responsibilities, the rate paid to ADHC providers shall be adjusted accordingly.

1. Effective January 1, 2009, the rate paid to ADHC providers on December 31, 2008 shall be reduced by $4.67 per day which is the cost of providing support coordination services separately.

2. This rate reduction will extend until such time that the ADHC provider's rate is rebased using cost reports that do not reflect the cost of delivering support coordination services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008).

Chapter 31. Reimbursement

Subchapter A. Prospective Payment System

§3101. General Provisions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2042 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2171 (October 2008), repromulgated LR 34:2576 (December 2008).

§3103. Cost Reporting

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2043 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2171 (October 2008), repromulgated LR 34:2576 (December 2008).

§3105. Cost Categories Included in Cost Report

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2045 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2576 (December 2008).

§3107. Nonallowable Costs

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2047 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2576 (December 2008).

§3109. Provider Reimbursement

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2048 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2576 (December 2008).

Subchapter B. Admission Assessment/Vendor Payment

§3121. BHSF Admission Assessment/Vendor Payment

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2049 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2576 (December 2008).

Chapter 33. Quality Assurance Monitoring

§3301. Utilization Review

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2050 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

§3303. Inspection of Care

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2051 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

§3305. Discharge Planning and Implementation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2053 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

Chapter 35. Appeals

§3501. General Procedures

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2055 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

§3503. Evidentiary Hearing

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2056 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

Chapter 37. Audits

§3701. Audits

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2057 (September 2004), repealed by the Department Of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

Chapter 39. Sanctions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2058 (September 2004), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2172 (October 2008), repromulgated LR 34:2577 (December 2008).

Implementation of the provisions of this proposed Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Alan Levine
Secretary

0812#077

RULE

Department of Health and Hospitals
Office of the Secretary
Office of Aging and Adult Services

Personal Care Services—Long Term
Louisiana Personal Options Program
(LAC 50:XV.Chapter 129)

The Department of Health and Hospitals, Office of Aging and Adult Services has amended LAC 50:XV.Chapter 129 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities to enable them to reside and remain safely in their own home. The mission of Medicaid funded personal care services is to supplement the family and/or community supports that are available to maintain the recipient in the community. This service program is not intended to be a substitute for available family and/or community supports. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. …

C. Authorization. Personal care services shall be authorized by the Department of Health and Hospitals, Office of Aging and Adult Services (OAAS) or its designee. The department, or its designee, will review the completed assessment, supporting documentation, plan of care or any other pertinent documents to determine whether the recipient

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ADULT DAY HEALTH CARE WAIVER (ADHC) PROVIDER MANUAL

Chapter Nine of the Medicaid Services Manual

Issued December 1, 2010

State of Louisiana
Bureau of Health Services Financing

ADULT DAY HEALTH CARE WAIVER

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E. Periodic Time Studies.--Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:

1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

5. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.

2314. LIMITATION OF ALLOCATION OF INDIRECT COSTS WHERE ANCILLARY SERVICES ARE FURNISHED UNDER ARRANGEMENTS

A. "No Overhead Allocation" Method.--

1. Where a provider furnishes ancillary services to Medicare patients under arrangements with others, the provider must pay the supplier and request reimbursement from the Medicare program. Where a provider simply arranges for such services for non-Medicare patients, and does not pay the non-Medicare portion of such services, its books will reflect only the cost of the Medicare portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the Medicare portion would result in excessive assignment of indirect costs to the program. Since services were also arranged for non-Medicare patients, part of the overhead costs should be allocated to that group.

Consequently, in the foregoing situation, no indirect costs may be allocated to the Medicare portion. Instead, the total indirect costs will be allocated to all other departments so that each of these departments will absorb proportionately those indirect costs which otherwise would have been allocated to the arranged for services. In this way, Medicare will share in such indirect costs in the proportion that it shares in the costs of all other services furnished directly by the provider.

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QUARTERS
6/30/2012

Medicaid per patients

JULY	4554
AUG	6025
SEPT	5604
OCT	4501
NOV	4753
DEC	4531
JAN	5063
FEB	4603
MAR	4798
APR	4431
MAY	4731
JUNE	3823
TOTAL	57417

Date Range: 07/01/11 - 07/31/11 **Target Population:** ALL
Detail: Daily

Case: ALL **SSN:** ALL **Name:** ALL

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-08/25/2011	200		673	673	$ 1776.72
				07/01/2011	36 / 36	36 / 36	
				07/05/2011	32 / 32	32 / 32	
				07/06/2011	37 / 37	37 / 37	
				07/07/2011	38 / 38	38 / 38	
				07/08/2011	37 / 37	37 / 37	
				07/11/2011	38 / 38	38 / 38	
				07/12/2011	38 / 38	38 / 38	
				07/13/2011	36 / 36	36 / 36	
				07/14/2011	34 / 34	34 / 34	
				07/15/2011	34 / 34	34 / 34	
				07/18/2011	35 / 35	35 / 35	
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	33 / 33	33 / 33	
				07/21/2011	7 / 7	7 / 7	
				07/22/2011	38 / 38	38 / 38	
				07/25/2011	37 / 37	37 / 37	
				07/26/2011	28 / 28	28 / 28	
				07/27/2011	26 / 26	26 / 26	
				07/28/2011	40 / 40	40 / 40	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 1776.72
				Total:			$ 1776.72

4554
4355
+199

Date Range: 07/01/11 - 07/31/11 **Target Population: ALL**
Detail: Daily

Case: ALL **SSN: ALL** **Name: ALL**

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-07/18/2011	200		236	236	$ 623.04
				07/05/2011	24 / 24	24 / 24	
				07/06/2011	20 / 20	20 / 20	
				07/07/2011	25 / 25	25 / 25	
				07/08/2011	24 / 24	24 / 24	
				07/11/2011	25 / 25	25 / 25	
				07/12/2011	21 / 21	21 / 21	
				07/13/2011	21 / 21	21 / 21	
				07/14/2011	36 / 36	36 / 36	
				07/15/2011	20 / 20	20 / 20	
				07/18/2011	20 / 20	20 / 20	
HR932		07/19/2011-08/18/2011	200		199	199	$ 525.36
				07/19/2011	22 / 22	22 / 22	
				07/20/2011	24 / 24	24 / 24	
				07/21/2011	23 / 23	23 / 23	
				07/22/2011	20 / 20	20 / 20	
				07/25/2011	20 / 20	20 / 20	
				07/26/2011	20 / 20	20 / 20	
				07/27/2011	21 / 21	21 / 21	
				07/28/2011	24 / 24	24 / 24	
				07/29/2011	25 / 25	25 / 25	
				Subtotal:			$ 1148.40
				Total:			$ 1148.40

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-05/11/2012	200		269	269	$ 710.16
				07/01/2011	33 / 33	33 / 33	
				07/08/2011	33 / 33	33 / 33	
				07/11/2011	34 / 34	34 / 34	
				07/15/2011	34 / 34	34 / 34	
				07/18/2011	34 / 34	34 / 34	
				07/22/2011	33 / 33	33 / 33	
				07/25/2011	33 / 33	33 / 33	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 710.16
				Total:			$ 710.16

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent	
HR932	[redacted]	07/01/2011-04/08/2012	200		192	191	$ 504.24	**Daily cap applied**
				07/12/2011	38 / 38	38 / 38		
				07/18/2011	37 / 37	37 / 37		
				07/26/2011	37 / 37	37 / 37		
				07/27/2011	41 / 41	40 / 40		**Daily cap applied**
				07/29/2011	39 / 39	39 / 39		
				Subtotal:			$ 504.24	
				Total:			$ 504.24	

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-01/21/2012	200		258	258	$ 681.12
				07/01/2011	29 / 29	29 / 29	
				07/05/2011	32 / 32	32 / 32	
				07/06/2011	34 / 34	34 / 34	
				07/07/2011	31 / 31	31 / 31	
				07/14/2011	29 / 29	29 / 29	
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	35 / 35	35 / 35	
				07/22/2011	34 / 34	34 / 34	
				Subtotal:			$ 681.12
				Total:			$ 681.12

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: Case #: SSN: Target: ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932	[redacted]	07/01/2011-01/23/2012	200		622	622	$ 1642.08
				07/01/2011	21 / 21	21 / 21	
				07/05/2011	25 / 25	25 / 25	
				07/06/2011	37 / 37	37 / 37	
				07/07/2011	23 / 23	23 / 23	
				07/08/2011	39 / 39	39 / 39	
				07/12/2011	39 / 39	39 / 39	
				07/13/2011	39 / 39	39 / 39	
				07/14/2011	38 / 38	38 / 38	
				07/15/2011	38 / 38	38 / 38	
				07/18/2011	38 / 38	38 / 38	
				07/19/2011	38 / 38	38 / 38	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	25 / 25	25 / 25	
				07/22/2011	26 / 26	26 / 26	
				07/25/2011	37 / 37	37 / 37	
				07/26/2011	27 / 27	27 / 27	
				07/27/2011	37 / 37	37 / 37	
				07/28/2011	37 / 37	37 / 37	
				07/29/2011	36 / 36	36 / 36	
				Subtotal:			$ 1642.08
				Total:			$ 1642.08

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-09/06/2011	200		189	189	$ 498.96
				07/01/2011	29 / 29	29 / 29	
				07/11/2011	31 / 31	31 / 31	
				07/12/2011	30 / 30	30 / 30	
				07/15/2011	28 / 28	28 / 28	
				07/18/2011	26 / 26	26 / 26	
				07/25/2011	28 / 28	28 / 28	
				07/29/2011	17 / 17	17 / 17	
				Subtotal:			$ 498.96
				Total:			$ 498.96

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-06/29/2012	200		154	154	$ 406.56
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	38 / 38	38 / 38	
				07/26/2011	38 / 38	38 / 38	
				07/27/2011	22 / 22	22 / 22	
				Subtotal:			$ 406.56
				Total:			$ 406.56

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: Case #: SSN: Target: ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-06/08/2012	200		478	478	$ 1261.92
				07/01/2011	22 / 22	22 / 22	
				07/05/2011	35 / 35	35 / 35	
				07/06/2011	26 / 26	26 / 26	
				07/08/2011	37 / 37	37 / 37	
				07/11/2011	35 / 35	35 / 35	
				07/12/2011	28 / 28	28 / 28	
				07/13/2011	27 / 27	27 / 27	
				07/14/2011	28 / 28	28 / 28	
				07/15/2011	36 / 36	36 / 36	
				07/18/2011	24 / 24	24 / 24	
				07/19/2011	31 / 31	31 / 31	
				07/20/2011	28 / 28	28 / 28	
				07/21/2011	24 / 24	24 / 24	
				07/25/2011	27 / 27	27 / 27	
				07/26/2011	24 / 24	24 / 24	
				07/28/2011	25 / 25	25 / 25	
				07/29/2011	21 / 21	21 / 21	
				Subtotal:			$ 1261.92
				Total:			$ 1261.92

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-11/03/2011	200		331	331	$ 873.84
				07/01/2011	24 / 24	24 / 24	
				07/05/2011	8 / 8	8 / 8	
				07/07/2011	30 / 30	30 / 30	
				07/12/2011	31 / 31	31 / 31	
				07/14/2011	33 / 33	33 / 33	
				07/15/2011	30 / 30	30 / 30	
				07/18/2011	28 / 28	28 / 28	
				07/19/2011	24 / 24	24 / 24	
				07/21/2011	8 / 8	8 / 8	
				07/26/2011	32 / 32	32 / 32	
				07/27/2011	22 / 22	22 / 22	
				07/28/2011	26 / 26	26 / 26	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 873.84
				Total:			$ 873.84

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-11/29/2011	200		111	111	$ 293.04
				07/11/2011	24 / 24	24 / 24	
				07/13/2011	21 / 21	21 / 21	
				07/20/2011	21 / 21	21 / 21	
				07/25/2011	24 / 24	24 / 24	
				07/27/2011	21 / 21	21 / 21	
				Subtotal:			$ 293.04
				Total:			$ 293.04

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-08/24/2011	200		383	383	$ 1011.12
				07/01/2011	36 / 36	36 / 36	
				07/06/2011	19 / 19	19 / 19	
				07/07/2011	25 / 25	25 / 25	
				07/08/2011	26 / 26	26 / 26	
				07/11/2011	30 / 30	30 / 30	
				07/12/2011	30 / 30	30 / 30	
				07/14/2011	28 / 28	28 / 28	
				07/15/2011	33 / 33	33 / 33	
				07/19/2011	28 / 28	28 / 28	
				07/20/2011	33 / 33	33 / 33	
				07/21/2011	28 / 28	28 / 28	
				07/22/2011	5 / 5	5 / 5	
				07/25/2011	32 / 32	32 / 32	
				07/26/2011	30 / 30	30 / 30	
				Subtotal:			$ 1011.12
				Total:			$ 1011.12

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ELDR

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-09/30/2011	200		460	460	$ 1214.40
				07/01/2011	25 / 25	25 / 25	
				07/05/2011	27 / 27	27 / 27	
				07/06/2011	12 / 12	12 / 12	
				07/07/2011	20 / 20	20 / 20	
				07/08/2011	26 / 26	26 / 26	
				07/12/2011	24 / 24	24 / 24	
				07/13/2011	27 / 27	27 / 27	
				07/14/2011	25 / 25	25 / 25	
				07/15/2011	24 / 24	24 / 24	
				07/18/2011	23 / 23	23 / 23	
				07/19/2011	24 / 24	24 / 24	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	25 / 25	25 / 25	
				07/22/2011	24 / 24	24 / 24	
				07/25/2011	25 / 25	25 / 25	
				07/26/2011	27 / 27	27 / 27	
				07/27/2011	27 / 27	27 / 27	
				07/28/2011	26 / 26	26 / 26	
				07/29/2011	27 / 27	27 / 27	
				Subtotal:			$ 1214.40
				Total:			$ 1214.40

Adult Day Healthcare Attendance Waiver July, 2011

#	Client Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Days
		31			31	31	31	31	0			31	31	31	31	31			31	31	31	18	31			31	31	31	31	31			607	20
		20			33	32	33	32	33			32	32	31	32	33			33	33	33	34	33			32	33	33	33	33			673	21
		31			0	31	31	31	33			31	31	32	31	31			31	31	31	33	31			31	31	31	31	31			625	20
		29			33	32	26	32	33			32	32	32	32	33			33	33	33	34	33			32	33	33	33	31			674	21
		26			0	27	0	30	32			0	32	0	31	31			0	31	28	32	0			0	31	0	29	30			390	13
		33			0	0	0	0	0			0	0	0	0	0			0	0	0	0	0			0	0	0	0	0			33	1
		33			33	32	33	32	33			32	32	32	32	33			33	33	33	34	28			32	33	33	23	33			672	21
		28			28	0	28	0	28			30	0	30	0	31			31	0	31	0	31			31	0	31	0	31			389	13
		28			28	0	28	0	28			30	0	30	0	31			31	0	31	0	0			31	0	31	0	31			358	12
		28			0	30	28	0	28			30	0	30	0	31			31	0	31	0	31			31	0	31	0	31			391	13
		31			33	31	31	31	33			31	31	31	31	31			31	31	31	33	31			31	31	31	31	31			657	21
		318			219	246	269	219	281			279	221	279	220	316			285	223	313	218	249			282	223	285	211	313			5469	176