STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified an Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

A. Payment for coinsurance and deductibles for Medicare non-institutional services not covered by Medicaid will be at 51% of Medicare's rate for the service.

STATE OF OREGON

1. (Reserved for future use)

"Pen & Ink" change

STATE OF OREGON

1. (Reserved for future use)

"Pen & Ink" change

TN# 95-09 Date Approved 5/2/96
Supersedes Effective Date 9/1/95
TN# 90-06 Comments Pen & Ink change authorized by State April 17, 1996

II. The following limitations apply to residents in intermediate care facilities for the mentally retarded or persons with related conditions:

A. The Division may make a reserved bed payment for those residents whose Plan of Care provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absence due to hospitalization. The MR/DD Specialist must be notified in writing of any resident's absence from the facility.

B. Prior to the resident's departure for leave to exceed 14 consecutive days, the facility must submit a written request to the MR/DD Specialist for authorization of reserved bed payments. In case of emergency, notification should be made as soon as possible; but in any event not later than the working day following the resident's departure.

1. Absences of less than 14 days do not require prior authorization, but the Division reserves the right to decline payment, if appropriate.

2. The MR/DD Specialist must notify the Division's Chief, MR/DD Medicaid Services, of any temporary absence in excess of 30 consecutive days. Prior authorization of such absences requires the signature of both the MR/DD Specialist and the Chief, MR/DD Medicaid Services.

C. The MR/DD Specialist shall notify the local AFS branch office in writing of any reserved bed denials. Reserved bed payments will not be made for a resident who does not return to the facility on or before expiration of any temporary or prior authorized absence unless the facility terminated the leave of absence and discharged the resident immediately upon learning the resident would not return to the facility.

D. Reserved bed payments shall be limited to 14 days in any 30-day period, except for those absences prior authorized by the MR/DD Specialist.

E. Failure of the facility to comply with the provisions of this rule shall relieve the Division and the Title XIX resident of all responsibility to make payment to the facility during the resident's absence. The provisions of this section are separate and apart from OAR 309-41-043.

F. Residents temporarily absent overnight or longer from the facility on activities under the supervision of and/or at the expense of the facility shall be considered as

remaining in the facility. This includes special trips of an educational or training nature, and recreational activities such as camping, fishing, hiking, etc.

G. If respite care is provided in a reserved bed, Title XIX billing shall be reduced by the amount of money received for this service. The AFS-483 billing form must indicate the name of the person receiving respite care and show a credit for the amount of money received for that care.

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

A. Reimbursement by the Senior and Disabled Services Division of the Department of Human Resources (Division) is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payor are not allowed;

B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;

C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;

D. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit: and

E. A proportionate share incentive adjustment to non-State operated governmental nursing facilities; and

Comment [BRM1]: We think that the percentil ceiling can fall w/i the 'fixed relationship' wording. It was originally used to describe the relationship percentage/benchmark. Assuming you are keeping pages 10-18- which describe historic rate setting procedures- then our next change starts on page 18, subsection 2(b).

Comment [BRM2]:

F. Annual review and analysis of allowable costs for all participating nursing facilities.

II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.

2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.

3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility requires one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division shall pay the basic rate plus the complex medical add-on rate to a provider as prospective payment in full.

2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid resident of a nursing facility whose care is reimbursed at the basic rate if the resident needs one or more of the following medication procedures, treatment procedures or rehabilitation services:

   a. Medication Procedures

      (1) Administration of medication(s) requiring skilled observation and/or judgment daily or more often for necessity, dosage and/or effect (This category does not cover routine oral medications or the use of oral antibiotics or the infrequent adjustments of a current stabilized medication routine);

      (2) Intravenous injections/infusions, heparin locks daily or more often for hydration or medication;

      (3) Sliding scale insulin injections daily or more often;

      (4) Intramuscular medications for unstable condition daily or more often;

      (5) External infusion pumps daily or more often if resident cannot self-bolus;

      (6) Hypodermoclysis daily or more often; or

      (7) Peritoneal dialysis daily or more often when resident unable to do own exchanges;

b. Treatment Procedures

(1) Nasogastric, gastrostomy/jejunostomy tubes daily or more often for feedings;

(2) Nasopharyngeal suctioning two times daily or more often and/or tracheal suctioning as required for a resident who is dependent on nursing staff to maintain airway;

(3) Percussion, postural drainage, and aerosol treatment when all three are performed two times daily or more often;

(4) Care and services for a ventilator dependent resident who is dependent on nursing staff for initiation, monitoring, and maintenance;

(5) Stage III or IV decubitus ulcers or ulcers related to circulatory impairment which require aggressive treatment and are expected to resolve;

(6) Open wound(s) which require aggressive treatment and are expected to resolve;

(7) Deep or infected stasis ulcers with tissue destruction equivalent to Stage III (eligibility for add-on retained until resolved or returned to previous chronic status);

(8) Short term, professional teaching implemented to satisfy a discharge or self-care plan;

(9) Emergent medical/surgical problems requiring short term professional nursing observation and/or assessment with approval from the Resident Care Review Specialist (eligibility for add-on retained until resident no longer requires professional observation and assessment for this medical/surgical problem); or

(10) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning (eligibility for add-on retained until resident no longer requires professional observation and assessment for this medical problem);

c. Rehabilitation Services

(1) Physical therapy performed at least 5 days every week;

(2) Speech therapy performed at least 5 days every week;

(3) Occupational therapy performed at least 5 days every week;

(4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or

(5) Respiratory Therapy authorized by Medicare, Medicaid Oregon Health Plan or a third party payor and performed by a respiratory therapist at least 5 days every week.

3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.

C. Pediatric Rate.

1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. the Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.

3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.

2. Swing Bed Eligibility. To qualify for a complex medical needs add-on payment, a hospital shall:

   a. Be approved by HCFA to furnish skilled nursing care as a Medicare swing bed hospital;

   b. Enter into a Medicare agreement to provide acute care; and

   c. Enter into an agreement with the Division to receive Medicaid payment for swing bed services.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located, the Division shall pay the lesser of:

   a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or

   b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment or an Extreme Outlier Client Add-on payment, or the pediatric rate.

4. Extreme Outlier Client Add-On.

a. The Division shall make an outlier client add-on payment when a ventilator-dependent client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

b. The add-on will be specific to the client's care needs, based on an extreme outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.

c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible Medicaid portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Minimum Wage Add-on.

   a. The Division shall add to the basic rate and the pediatric rate a minimum wage add-on payment to reimburse facilities for the cost of implementing changes in the Oregon minimum wage law:

      (1) From $4.75 to $5.50 effective January 1, 1997;

      (2) From $5.50 to $6.00 effective January 1, 1998; and

      (3) From $6.00 to $6.50 effective January 1, 1999.

   b. The minimum wage add-on to be paid from July 1, 1997 to June 30, 2001 will be calculated as a weighted average add-on paid in addition to the basic rate and the pediatric rate based on payroll data for December 1996, September 1998 and September 1999 supplied by nursing facilities.

8. Proportionate Share Incentive Adjustment.

   a. The Division recognizes that non-State operated governmental nursing facilities provide care to many clients who are medically complex and fragile.

   b. The Division will ensure continued access to this level of care through proportionate share incentive adjustment payments to each non-State operated governmental nursing facility.

   c. The proportionate share incentive adjustment shall be paid at least

annually for each State Fiscal Year. The payment to each facility is in proportion to the facility's Medicaid days during the cost reporting period that ended immediately preceding the State Fiscal Year relative to the sum of all Medicaid days during the same period for facilities eligible and participating in the adjustment. The total funds for the incentive payment are established each State Fiscal Year subject to the anticipated level of nursing facility payments within the year and to the payments limits of 42 CFR 447.272.

III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Flat Rate and Complex Medical Needs Add-on Rate.

A. Financial Reporting and Facility Auditing.

1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.

2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.

B. Calculation of the Standard Statewide Flat Rate and Complex Medical Needs Add-on Rate.

Effective July 1, 1997 and through June 30, 1999 (the 1997/99 biennium),

the Standard Statewide Flat Rate or Basic Rate is referred to as the Transition Period Basic Rate. Effective July 1, 1999, the Standard Statewide Flat Rate is referred to as the Post Transition Period Basic Rate. The Transition Period Basic Rate consists of a Direct Care component and Indirect Care component. The Post Transition Period Basic Rate is based on allowable costs.

1. Transition Period Basic Rate and Complex Medical Needs Add-on Rate.

   a. Direct Care Component of the Transition Period Basic Rate. The Direct Care Component is based on the Statements received by the Division by December 91, 1996, for fiscal reporting periods ending September 30, 1996, or earlier (reporting Year). The Division desk reviews or field audits the Statements and for each facility determines a total allowable direct care (Direct Compensation, Direct Care Supplies and Food) cost per diem, hereafter referred to as the Direct Care Cost. For each facility, its Direct Care Cost is inflated using the percentage increase determined as follows:

      A Direct Care Cost statewide weighted average is determined for the Base Year and compared to a Direct Care Cost statewide weighted average for the preceding fiscal period, resulting in a percentage increase in Direct Care Cost.

      This percentage increase is applied to each facility's fiscal year that ends in the 1997/99 biennium.

      For each facility's fiscal year ending during the 1997/99 biennium, its Direct Care Cost is limited to a Direct Care.

Ceiling calculated as follows:

The Direct Care Cost is inflated to reflect changes in the DRI Index from the mid-point of each facility's reporting period to the mid-point of the transition period beginning July 1, 1997. The Direct Care Cost as adjusted for DRI inflation for all facilities are then ranked and the 70th percentile (Direct Care Ceiling) determined.

The Direct Care Ceiling as determined is inflated to the mid-point of each facility's fiscal year that ends during the 1997/99 biennium. The inflation factor used in each case will be the projected change in the DRI Index for calendar year 1997.

b. The Indirect Care Component of the Transition Period Basic Rate. Effective July 1, 1997, the Indirect Care Component of the Transition Period Basic Rate is the Indirect Care Rate effective July 1, 1996 inflated to July 1, 1997 using the projected change in the USCPI between December, 1996 and December, 1997, and then adding 2 cents a resident day to comply with OBRA 1987. The Indirect Care Rate is a flat rate established as the statewide weighted average rate. The Indirect Care Rate was phased in over four years beginning with the fiscal period ending June 30, 1992, so that in the fifth year all nursing facilities would receive the same indirect rate. To calculate the Indirect Care Rate, the rates for Property, Administration and Other Support that each facility would have received under the system in effect on June 30, 1991, were calculated as if the system had continued

in existence, with one exception. For facilities with less than 95% occupancy rates, per resident day Administration and Other Support costs were adjusted to what they would have been at 95% occupancy; this adjustment was made by dividing allowable Administration and other Operating Support costs by the number of resident days facilities would have had if they had been 95 percent full during the relevant cost reporting period. These three rates were then combined to form the "base indirect rate" for each facility. To calculate the weighted average, the base indirect rate was multiplied by the facility Medicaid days. The sums of all of these calculations were added together and divided by total Medicaid days to arrive at the statewide weighted average. To establish July 1, 1993 rates, these adjusted 1991 rates were inflated by the one-year change in the National Nursing Home Market Basket as measured in the fourth quarter of 1991; plus thereafter, rates were inflated on July l by the change in the US CPI for the previous calendar year. For example, the Indirect Care Rate as of July 1, 1997 is inflated to July 1, 1998 using the projected change in the USCPI between December, 1996 and December, 1997. The statewide weighted average rate was not rebased. However, a statewide indirect add-on rate was computed to account for indirect costs previously included in direct cost accounts. The method for calculating the indirect add-on was as follows. Costs of inservice directors, central supply clerks and leased oxygen equipment appearing in the Statements used to set the indirect rates were identified and summed. For each facility, these costs were divided by the greater of the number of the resident days the nursing facility actually reported on the Statement used to set the 1991

rates, or the number of days the facility would have had at 95 percent occupancy. This calculation resulted in an add-on to the facility specific indirect rate. The statewide indirect add-on rate was computed by multiplying the facility specific rates by the number of Medicaid resident days for each facility. The sums of all these calculations were added together and divided by the total number of Medicaid days to arrive at the statewide weighted average.

The Indirect Care Rate was phased in over five years, from State Fiscal Year 1991-92 through State Fiscal Year 1995-96. Each year of the phase-in period, a larger share of the rate received by each facility is comprised of the statewide average (see following table).

Indirect Rate Phase-In

State Fiscal Year	% Facility Specific	% Statewide Average
1991-92	80%	20%
1992-93	60%	40%
1993-94	40%	60%
1994-95	20%	80%
1995-96	0%	100%.

The Indirect Care Rate was inflated each July 1 by the US CPI. During the phase-in period, facility specific rates were inflated by the same factor.

c. Initial Transition Period Weighted Average Rate. For each facility, its Direct Care Cost as adjusted for inflation and subject to the Direct Care Ceiling is combined with the Indirect Care Rate resulting in a facility specific weighted average rates. A statewide

weighted average rate (the Initial Transition Period Weighted Average Rate) is then determined by applying each facility's specific weighted average rate against its total number of patient days in its Base Year.

d. Initial Transition Period Base Pool. The Initial Transition Period Weighted Average Rate is next applied to the projected caseload for the 1997/99 biennium to arrive at the Initial Transition Period Base Pool.

The number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996, are then determined and the total number of clients is multiplied by the pediatric rate determined in II.C. as adjusted for inflation using the DRI. The resulting amount is subtracted from the Initial Transition Period Base Pool resulting in an Initial Transition Period Base Pool excluding pediatric costs.

e. Complex Medical Needs Add-on. The Initial Transition Period Base Pool after removal of pediatric costs is divided by the projected caseload for the 1997/99 biennium less the number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996, resulting in an Initial Transition Period Non-Pediatric Basic Rate. Forty percent (40%) of this rate is the Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is applied to the number of clients in facilities who met the Complex Medical Needs Add-on criteria (II.B.) in June 1997. The resulting amount is then subtracted from the Initial Transition Period Base Pool after removal of pediatric costs resulting in an Initial Transition Period Base Pool after the removal of pediatric costs and Complex Medical Needs Add-on costs.

f. Transition Period Basic Rate. The Initial Transition Period Base Pool after removal of pediatric and Complex Medical Needs Add-on costs is then divided by the projected caseload for the 1997/99 biennium, less the pediatric caseload (number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996) and the Complex Medical Needs Add-on caseload (the number of clients in facilities who meet the Complex Medical Needs Add-on criteria in June 1997), resulting in the Transition Period Basic Rate.

The Division determines as of November 30, 1997, May 31, 1998, and November 30, 1998, the number of clients in each facility on whose behalf payments are made at the Transition Period Basic Rate and the number of clients subject to the Complex Medical Needs Add-on Rate. Deviations in the pediatric caseload (number of clients in pediatric nursing facilities or in self-contained pediatric nursing units as of December 31, 1996) and Complex Medical Needs Add-on caseload (the number of clients in facilities who meet the Medical Add-on criteria in June 1997) will result in the Transition Period Basic Rate being adjusted to ensure that the Initial Transition Period Base Pool remains constant. The recalculated Transition Period Basic Rate becomes effective on the first day of the second calendar month following the date of the recalculation. The Transition Period Basic Rate effective July 1, 1998, is based on the Transition Period Basic Rate recalculated on May 31, 1998 and adjusted for inflation using the DRI.

2. Post Transition Period Basic Rate and Complex Medical Needs Add-on Rate.

a. Initial Post Transition Period Basic Rate. For the first year of each biennium (the Rebasing Year), the Post Transition Period Basic Rate is based on the Statements received by the Division by September (or postmarked by October 31, if an extension of filing has been approved by the Division) for the fiscal reporting period ending on June 30 of the previous even-numbered year, e.g., for the biennium beginning July 1, 1999, Statements for the period ending June 30, 1998 are used. Statements for pediatric nursing facilities are not used to determine the Post Transition Period Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit, if any.

For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the Post Transition Period Base Year (e.g., for the biennium beginning July 1, 1999, the Post Transition Period Base Year is the fiscal period ending June 30, 2000) by projected changes in the DRI Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit as reported in the Statement.

A Statewide Weighted Average Allowable Costs Per Medicaid Day (the Initial Post Transition Period Basic Rate) is determined by applying the Allowable Costs Per Medicaid Day for each facility to its total Medicaid days excluding days in a self-contained pediatric unit as reported in the Statement, summing the computations for all applicable facilities, and dividing the results by the total resident days (excluding total days in self-contained pediatric units) for all facilities.

b. Post Transition Period Basic Rate for the period July 1, 1999 through June 30, 2003. The relationship that the Transition Period Basic Rate effective July 1, 1997 bears to the Initial Transition Period Weighted Average Rate (excluding pediatric facilities and self-contained pediatric units) is determined. The resulting percentage (Benchmark) is used to determine the Post Transition Period Basic Rate for the first year of the biennium. The Benchmark is applied to the Initial Post Transition Period Basic Rate to determine the Post Transition Period Basic Rate for the first year of the biennium.

The Post Transition Period Basic Rate for the second year (Non-Rebasing Year) of the biennium is the Post Transition Period Basic Rate for the first year, inflated by the DRI Index.

c. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Post Transition Period Basic Rate.

d. Rebasing Year Adjustment. In a Rebasing Year in which the Post Transition Period Basic Rate is less than the Post

Transition Period Basic Rate in the prior Rebasing Year adjusted for inflation using the DRI, the Post Transition Period Basic Rate for the new Rebasing year will be increased by one-half the difference between the two rates.

3. For the period beginning July 1, 2003 through June 30, 2005, new Basic Rates are computed by eliminating the Benchmark and replacing it with the 63rd percentile of allowable costs (both direct and indirect).

4. For the period beginning July 1, 2005 through June 30, 2007, the Benchmark is eliminated and replaced with the 70th percentile of allowable costs (both direct and indirect).

5. The Basic Rate established in steps B.3. and B.4. above is inflated by the DRI Index in the second year (the Non-Rebasing Year).

6. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.

C. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

2. Pediatric nursing facilities will be paid a per diem rate of $188.87 commencing on August 1, 1999, which rate will:

a. Be prospective;

b. Not be subject to settlement; and

c. The per diem rate will be calculated as follows:

The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days. The base year will be 1998. Once the weighted average cost is determined, the rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

On July 1 of each non-rebase year after 1999, the pediatric rate will be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate setting will occur in alternate years. Rebasing of pediatric nursing facility rates will be calculated using the method described above.

3. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.

D. Licensed Nursing Facility With a Self-Contained Pediatric Unit.

1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.

2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.

3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

IV. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

V. 2003 State Legislative Changes (change in the definition of allowable costs.)

a. Nursing Facility Assessments. The nursing facility assessment is an allowable Medicaid cost.

INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED AND OTHER DEVELOPMENTALLY DISABLED PERSONS (ICFs/MR)

Reimbursement for services provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) for Medicaid recipients is made by the Mental Health and Developmental Disability Services Division (the Division). The Division determines rates in accordance with the following principles, methods, and standards which comply with 42 CFR 447.250 through 447.256.

I. Reimbursement Principles

The payment methodology for ICFS/MR is based on the following:

A. Development of model budgets which represent 100% of the reasonable costs of an economically and efficiently operated facility;

B. Annual review and analysis of allowable costs;

C. The use of interim rates (per diem) and retroactive year-end cost settlements, capped by a maximum allowable cost for each facility based on the type of facility and resident classification; and

D. The lower of allowable costs or maximum costs.

II. Classification of ICF/MR Facilities

Three classes of ICFs/MR have been established based on classification of residents, size of the facility, and staffing requirements.

A. "Small Residential Training Facility" (SRTF) means a Title XIX certified facility having fifteen or less beds and providing active treatment.

B. "Large Residential Training Facility" (LRTF) means a Title XIX certified facility having from 16 to 199 beds that provides active treatment. The LRTF model budget may be applicable to a SRTF which is constructed and programmed to serve residents who are not capable of self-preservation in emergency situations.

C. "Full Service Residential Training Facility" (FSRTF) means a facility having 200 or more certified ICF/MR beds providing the full range of active medical and day treatment services required in state and federal rules and regulations. The facility may be less than 200 beds if it meets all of the following criteria:

1. It is a certified ICF/MR and is licensed as a nursing home for the mentally retarded;

2. It serves a high percentage of clients who are non-ambulatory, medically fragile or in some other way seriously involved;

3. Its location is such that professionals with the knowledge of medical and dental needs of people with severe mental and physical handicaps are not generally available and must be hired as permanent staff;

4. It serves any and all clients referred by the Division.

III. Classification of Residents

The classification of each resident in an ICF/MR is determined by use of the Division's Resident Classification Instrument.

A. "Class A" includes any of the following:

1. Children under six years of age;

2. Severely and profoundly retarded residents;

3. Severely physically handicapped residents; and/or

4. Residents who are aggressive, assaultive or security risks, or manifest severely hyperactive or psychotic-like behavior.

B. "Class B" includes moderately mentally retarded residents requiring habilitative training.

C. "Class C" includes residents in vocational training programs or sheltered employment. These training programs or work situations must be an integral part of the resident's active treatment program.

IV. Rate Setting - SRTFs and LRTFs

A. For each SRTF and LRTF, the Division develops an interim rate based upon the actual licensed capacity and staffing ratios

required under the administrative rules to serve the anticipated mix of class A, B, and C residents. See pages 7 through 10 of this portion of the State plan for examples of the model interim rate worksheets. Each interim rate is calculated as the lesser of the facility's model budget rate (1) or projected net per them cost (2).

1. The model budget represents 100% of reasonable per them costs of efficiently and economically operated facilities of that size.

   a. The model budget consists of two major cost categories: Base Costs and Labor Costs.

      i. Base Costs (e.g., rent, utilities, administration, general overhead) are based on amounts determined by the State to be reasonable in similar sizes and types of residential facilities. The model budget rate consists of a standard per diem rate per resident for each class of facility.

      ii. Labor Costs (e.g., for direct care, active treatment, and support staff) are broken into various components. The model budget cost-for each component is developed based on requirements in federal regulations, State regulations, the State's experience in State-operated ICFs/MR, and costs determined to be reasonable in similar facilities. Each component within the labor category has a model budget rate developed.

   b. The facility's model budget rate is adjusted by the most recently available resident occupancy information, but not lower than 95% of the facility's licensed bed capacity.

      i. The model budget rate at 100% occupancy is multiplied by the number of resident days at 100% occupancy to yield the ceiling amount in dollars.

      ii. The ceiling amount is divided by the greater of:

      The number of resident days projected for the facility for the upcoming fiscal period; or

      95% of the total possible resident days available for a facility of that licensed capacity for the fiscal period.

   c. Model budgets for SRTFs and LRTFs are reviewed annually and adjustments are made based on inflation, economic

trends or other evidence supporting rate changes, such as directives from the legislature or changes in program design.

d. Model budgets will be rebased as a result of desk or field audits of the providers' cost statements.

2. The projected net per diem cost is usually derived from the facility's latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods. Adjustments have historically fallen into four categories:

a. Corrections to depreciation;

b. Modifications of indirect cost allocations;

c. Unallowable costs; or

d. Offsets of expenses against income and donations as described in the administrative rules.

However, if requested by the facility and agreed to by the Division, the facility may substitute actual allowable costs gathered from at least three months of data more recent than the latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods.

a. The Division will consider recent data which is the equivalent of an interim cost report by the facility.

b. The Division will compare actual allowable costs derived from the recent data with the model budget rate and will assign a new interim rate based upon the lesser of the two.

3. The facility or the Division may request a per diem rate adjustment if a significant change in allowable costs can be substantiated.

4. The Division pays an interim rate to each SRTF and LRTF through the end of each fiscal year. The actual (final) payment, called the year-end settlement, is discussed in part B of this section.

In the year-end settlement, the Division takes into account the interim rate payments already made and compares those payments with the settlement rate.

B. For each SRTF and LRTF, the Division establishes a year-end settlement rate on a retrospective basis for the period covered by the respective cost statements and issues an official notice to each facility indicating the exact amount of the retroactive settlement. The settlement rate is calculated as the lower of the ceiling rate (1) or the actual net per them cost (2):

1. Ceiling rate: The facility's model budget rate will be revised, using the worksheets shown at pages 8 through 10 of this portion of the State plan, to reflect the actual number and classification of residents for the period. The product of the resulting revised rate at 100% occupancy and the number of resident days at 100% occupancy shall be the ceiling amount in dollars. The quotient of the ceiling amount and actual resident days in the period will be the ceiling rate subject to the following modifications:

   a. If the facility is occupied at 95% or more of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and actual resident days in the period shall be the ceiling rate.

   b. If the facility is occupied at less than 95% of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and product of 95% of the licensed bed capacity and the number of calendar days in the fiscal period shall be the ceiling rate.

2. Actual net per diem cost The quotient of actual allowable costs, as adjusted in accordance with this plan, and actual resident days for the period, shall be the actual net per diem cost.

3. The methodology for calculating the year-end settlement rate and amount for SRTFs and LRTFs is shown on pages 11 and 12 of this portion of the State plan.

V. Rate Setting - FSRTFs

A. For each FSRTF, the Division develops an interim rate based on the facility's projected costs. The facility or the Division may request a rate adjustment if the basis for the prospective rate has changed and a significant change in projected costs can be substantiated.

B. For each FSRTF, the Division develops a year-end settlement rate based upon actual costs.

VI. Costs and Services Billed

A. Reimbursement by the Division is based on an all-inclusive rate, which constitutes payment in full for ICF/MR services. The-rate established for an ICF/MR includes reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Payment for costs outside of the all inclusive rate may be authorized in specific circumstances according to criteria established in Oregon Administrative Rules. These include: the circumstance of an individual admitted to or residing in a privately operated ICF/MR who needs diversion or crisis services in order to avoid admission to a state-operated ICF/MR; the circumstance of an individual not admitted to, but residing in, a privately operated ICF/MR who is occupying a vacant or reserved bed and needs diversion or crisis services; and the circumstance of costs incurred which are related to the approved plan for diversion or crisis services.

B. Billings to the Division shall in no case exceed the customary charges to private clients for any like item or service charged by the facility.

C. The Division may make a reserved bed payment for those residents whose Individual Program Plan provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absences due to hospitalization or convalescence in a nursing facility. Reserved bed payments shall be limited to 14 days in any 30 day period unless prior authorized by the Division. Reimbursement will only be made to providers who accept Title XIX payment as payment in full.

VII. Cost Statements Audited

The Division shall audit each ICF/MR cost statement within six (6) months after it has been properly completed and filed with the Division. The audit will be performed either by desk review or field visit.

VIII. Provider Appeals

A letter will be sent notifying the provider of the interim per diem rate and/or the year-end settlement rate. Providers shall notify the Division in writing within 15 days of receipt of the letter, if the provider wishes to appeal the rate. Letters of approval must be postmarked within the 15 day limit.

EXAMPLE ONLY

Calculation of Interim Rate
July 1, 1991

Cost From Fiscal Year 1989-90 Audit Report	$96.69 (1)
July 1, 1990 Inflation Factor	1.04
	100.56
July 1, 1991 Inflation Factor	1.044
Projected Net Per Diem Cost	$104.98
Adjusted Model Budget Rate	$ 99.50
Lower Amount is New Interim Rate	$ 99.50

(1) Cost statement and desk review for FY 1990-91 not available at time of interim rate calculation.

INTERIM RATE
FOR JULY 1, 19

EXAMPLE ONLY

Category		Original Model Budget	Adjustments		Adjusted Model Budget
I	Base Costs	$0.00	$0.00		$0.00
II	Administration				
	A. Administrator	0.00			0.00
	B. Assistant Administrator	0.00			0.00
	C. Other Administration	0.00			0.00
	Sub-Total	0.00	0.00		0.00
III	Active Treatment				
	A. Psychology	0.00			0.00
	B. Social Work	0.00			0.00
	C. Speech Therapy	0.00			0.00
	D. Physical Therapy	0.00	0.00	3.	0.00
	E. Occupational Therapy	0.00			0.00
	F. Recreational Therapy	0.00			0.00
	Sub-Total	0.00	0.00		0.00
IV	Direct Care Staffing	0			0
	A. Direct Care Staff	0.00	0.00	4.	0.00
	B. Supervisory Staff	0.00	0.00	5.	0.00
	Sub-Total	0.00	0.00		0.00
V	Other Staff				
	A. Skill Trainer/QMRP	0.00			0.00
	B. Nursing	0.00			0.00
	C. Pharmacist	0.00			0.00
	D. Dentist	0.00			0.00
	E. Dietitian	0.00			0.00
	F. Food Service	0.00			0.00
	G. Laundry	0.00			0.00
	H. Housekeeping	0.00			0.00
	I. Maintenance	0.00			0.00
	J. In-Service Training	0.00			0.00
	K. Receiving/Warehousing	0.00			0.00
	Sub-Total	0.00	0.00		0.00
VI	Medical Services	0.00	0.00		0.00
VII	Day Programs	0.00	0.00		0.00
	TOTAL	$0.00	$0.00		$0.00

INTERIM RATE
FOR JULY 1, EXAMPLE ONLY

1. Period	Days in Period	X	Licensed Beds	=	Capacity Days
7-1-90 thru 6-30-91	365		0		0

2. Residents by Classification (By Cottage)	Resident Days	/	Days in Period	=	Average Residents by Classification
A.	0		365		0.00
B.	0		365		0.00
C.			365		0.00
Total	0		365		0.00

3. Physical Therapy Classification	Hours Per Day per Resident	X	Average Residents Per Day	=	Resident Hours Per Day
A.	0.11		0.00		0.00
B.	0.04		0.00		0.00
C.	0.01		0.00		0.00
Total	0.16		0.00		0.00

Hourly Rate	14.04
Daily Rate (Total * Hourly Rate)	0.00
Average Residents per Day	0
Per Resident Day (Daily Rate*Average Residents)	
Per Resident Day Adjustment	1.16
Total per Resident Day	

INTERIM RATE
FOR JULY 1, 19 EXAMPLE ONLY

4. Direct Care Staff

Classification	Average Res. Days	/=	Shift	/=	Shift	/=	Shift	Total
A.	0	8	0.000	8	0.000	16	0.000	
B.	0	16	0.000	8	0.000	16	0.000	
C.	0	32	0.000	16	0.000	32	0.000	
Total	0		0.000		0.000		0.000	
Rounded Total			0		0		0	= 0
Posting Factor								X 1.63
Total Staff								0.00
Rounded								1

0 Staff X 40 Hrs X 52 Wks / 365 Days / 84 Avg Res Per Day

X $6.26 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

5. Direct Care Supervisory Staff

0 Direct Care Staff / 7 = 0.00 Supervisors Rounded 0
0 Staff X 40 Hrs X 52 Wks 365 Days / 84.00 Avg Res Per Day

X $6.16 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

EXAMPLE ONLY

SETTLEMENT COMPUTATION
For the Period 7-1-90 through 6-30-91

	7/1/90 Through 6/30/91
Model Budget @ 100% Capacity	$95.32
Capacity Days	3,650
Ceiling Dollars	$347,918.00
Actual Resident Days	3,554
Ceiling Rate	$97.89
Total Expenditures Per Cost Statement	$341,072.00
Less: Adjustments	.00
Net Allowable ICF/MR Expenditures	$341,072.00
Actual Resident Days	3,554
Actual Net Per Diem Cost	$95.97
Settlement Rate (Lesser of Ceiling	
or Actual Net Per Diem Cost)	$95.97

EXAMPLE ONLY

COMPUTATION OF SETTLEMENT AMOUNT
For the Period 7-1-90 through 6-30-91

The following computation for the period 7-1-90 through 6-30-91 discloses that:

1. The ICF/MR owes the Mental Health Division
or
2. The Mental Health Division owes the ICF/MR $1,916.40

ICF/MR FACILITY VENDOR #

Mo./Yr. Service	Settlement Rate	Interim Rate	Settlement rate minus Interim Rate	Resident Days	Amount
7/90	$95.97	$96.59	(1) ($.62)	310	($192.20)
8/90	95.97	95.32	.65	310	201.50
9/90	95.97	95.32	.65	270	175.50
10/90	95.97	95.32	65	279	181.35
11/90	95.97	95.32	.65	270	175.50
12/90	95.97	95.32	.65	305	198.25
1/91	95.97	95.32	.65	310	201.50
2/91	95.97	95.32	.65	280	182.00
3/91	95.97	95.32	.65	310	201.50
4/91	95.97	95.32	.65	300	195.00
5/91	95.97	95.32	.65	310	201.50
6/91	95.97	95.32	.65	300	195.00
			Total		$1,916.40

Facility _____
_____
_____

(1) This interim rate was paid prior to the rate revision in the letter dated 7-30-90.

TN# 91-27 Date Approved: 8/24/92
Supersedes TN# ---- Effective Date : 10/1/91

Transmittal # 80-31

Instructions for Preparation of the Newly Revised AFS ICF/MR Cost Statement

INTRODUCTION

The following instructions, based on the rules in the ICF/MR provider guide, will help clarify and give direction in completing the ICF/MR Cost Statement. Additional explanation to specific questions may be obtained by contacting Adult and Family Services Division. FSRTFs may disregard these instructions and use the Medicare Form 2552 portion of the ICF/MR Cost Statement and chart of accounts.

FILING OF ICF/MR COST STATEMENT

Generally, cost statements are filed on an annual basis, and are due within 90 days of the facility's REPORTING period end. Improperly completed or incomplete cost statements will be returned for proper completion, to be returned to AFS within 30 days. See Rule 461-17-920 of the ICF/MR provider guide for further explanation.

MIXED LEVEL-OF-CARE FACILITIES

If a facility provides either a skilled or semi-skilled level of care in addition to the ICF/MR level of care, the Nursing Home Cost Statement shall be completed first, so that only those dollar amounts related to the ICF/MR level of care are entered on the ICF/MR Cost Statement.

If a legal entity operating an ICF/MR program also operates programs or businesses not reimbursable under Title XVIII or Title XIX, at its discretion, the facility may decide to separate the non-ICF/MR costs before the cost statement is done, or in the adjustment column of the cost statement.

Page 1

The first page of the cost statement is used to identify the facility, list the facility's public billing rates, provide space for signature by the responsible parties, and provide space for other related information.

SIGNATURES

Both the preparer, if not an employee of the provider, and the owner or individual who normally signs the Federal Income Tax Return or other report shall sign the ICF/MR Cost Statement.

Page 2

The second page is used to identify the owners and officers, their ownership interest in the facility, services they performed for the facility, and other related information.

Page 3

The third page is used to identify other businesses with which the owners are involved, the facility administrator, and other related information.

ADMINISTRATOR SUMMARY

Include all of the designated administrators for the cost statement period and their dates of service as administrator of the facility. Also, list the current administrator.

ST. OR SA Approved 12/22/80 RO Approved 1/20/81

Effective 1/1/81

TN# 80-31 Date Approved: 1/20/81
Supersedes TN # --- Effective Date : 1/1/81

ST. OR SA Approved 12/22/80 RO Approved 1/20/81

Effective 1/1/81

Page 4

The fourth page provides space for additional explanation of any item on the cost statement, and space for information on the facility and equipment.

Page 5

Page 5 is the beginning of the financial section of the cost statement.

FINANCIAL SECTION

The financial section of the cost statement has been designed so that a provider can determine his net allowable costs, and determine by cost finding his per diem cost for the ICF/MR program.

REVENUE SCHEDULE

The provider shall include all of his revenue by appropriate account as described in the chart of accounts.
Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all revenue of the facility and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS Reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

Any difference between net income per ICF/MR Cost Statement and net income per IRS report shall be reconciled on Schedule A.

The second column shall include revenues allocable from a home office net of adjustments and reclassifications.

The third column is designed so the provider can make adjustments and reclassifications to the gross revenue shown in the first column. These adjustments and reclassifications shall be made according to the provisions of the ICF/MR provider guide before the cost statement is submitted.

The first three columns total to the fourth column.

Page 6

Page six is the beginning of the base cost schedule.

BASE AND LABOR COST SCHEDULES

The provider shall include all of his expenses by appropriate account as described in the chart of accounts.

Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all expenses of the facility, and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

The second column shall include expenses allocable from a home office. This column shall be reconcilable to the home office financial statements and records. The amounts allocated shall be net of reclassifications and adjustments per provisions of this guide. See Rule 461-17-890 of the ICF/MR provider guide.

The third column is designed so the provider can make adjustments and reclassifications to the gross facility expenses in the first column per provisions of the ICF/MR provider guide. These adjustments and reclassifications shall be made before the ICF/MR Cost Statement is submitted to the Division.

If an adjustment is for a revenue producing activity relating to a non-allowable cost, the revenue shall be offset against the appropriate expense if the revenue is less than two per cent of the total provider expense. If the revenue is greater than two percent of the total provider expense, costs must be allocated to this area as described in the discussion for Cost Area Allocations.

The fourth column shall include only the net allowable costs attributable to the provider per the provisions of this guide. The first three columns total to the fourth column.

Page 7

Page seven is the last page of the base cost schedule.

Page 8

Page eight is the beginning of the labor cost schedule. See the instructions for base and labor costs above.

Page 9

Page nine is the last page of the labor cost schedule.

Page 10

Page ten shows in total the payroll taxes which are to be allocated to the various labor cost categories, and provides a form for the return on owner's equity calculation.

SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

The allowable Total Employee Benefits and Taxes (Acct. #3200), is to be allocated to the appropriate payroll and employee benefits account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON EQUITY

The return on owner's equity is calculated on page 10 of the cost statement. The rate of return is identified in Rule 461-17-860 of the IFC/MR provider guide. This same rule defines allowable equity to be included in the per diem rate. Non-profit corporations should not make this calculation since they are not allowed a return on equity.

Page 11

Page 11 is the first page of the balance sheet, and is used to identify the facility's assets.

The balance sheet must be completed as it is presented in the ICF/MR Cost Statement. Substituting another balance sheet will not suffice.

Page 12

Page 12 is the last page of the balance sheet, and is used to show the facility's liabilities and capital.

Page 13

COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES WITH OTHER REVENUE PRODUCING PROGRANIS

This schedule is designed to develop the ratios to be used in allocating costs to different levels of care. If a facility provides either a skilled or semiskilled level of care in addition to the ICF/MR level of care, or operates programs or businesses not reimbursable under Title XVIII or Title XIX, see "Mixed Level of Care Facilities" above. If there is no revenue producing activity related to non-allowable cost5 which generates revenue in excess of 2-, of the total gross expenses, this schedule need not be completed.

If an allocation method other than that specified in the schedule is Used, an explanation of the method and reason for its use must be provided on page 4 of the cost statement. A supplement to the schedule may be needed if there is insufficient space to adequately show a different allocation. The use of a different allocation method is to be used only if it is more reasonable and accurate than the prescribed method, and is subject to approval by the Division.

Each level-of-care column should contain the resident days or square related to that level-of-care by cost area as designated on the schedule. If the designation is for resident days, resident days by licensed bed in the designated ICF/MR area should be used. If the designation is for square footage of common areas, including dining, administrative offices, etc. should not be included in the square footage totals where they are used, in the same proportionate ratio by all levels of care.

The allocation base column is the total of the level-of-care columns for each cost area.

The net cost area expense column shows the dollar amount of net allowable expenses for each cost area.

The multipliers shown in the last column are used to develop the dollar amounts for the Allocated Costs schedule. Each multiplier is computed by dividing the net cost area expense by the allocation base for that cost area. If costs can be directly related to a level of care, such as might be the case for certain salaries, a multiplier should not be developed since the costs can be entered directly on the Allocated Costs schedule.

Page 14

ALLOCATED COSTS SCHEDULE

This schedule is designed to show allowable costs for the ICF/MR program by cost area, and to calculate the ICF/MR cost per day.

If no allocation via the Cost Area Allocations schedule is required, the dollar amount for each cost area will be the total net allowable expense from the base and labor cost schedules. If the allocations schedule was used, the dollar amount for each cost area is the product of the multiplier for that cost area and the level-of-care sub-total from page 13.

The grand total of the ICF/MR cost areas divided by resident days by licensed bed in the designated ICF/MR service area determines the ICF/MR cost per day.

Page 15

Page 15 provides space for explanation of the miscellaneous accounts and other accounts as needed, and space for reconciliation calculations.

Page 16

RESIDENT CLASSIFICATION REPORT

If the resident day count by level of care is the same as the resident day count by licensed bed, this should be-indicated on the second schedule of this report instead of unnecessarily repeating the day count.

Page 17

BED CAPACITY SCHEDULE

The "change" columns of this schedule should indicate the total number of beds at the date of change in the number of beds.

STAFFING RATIO REPORT FOR DIRECT CARE STAFF

Only the direct care staff as defined in the ICF/MR provider guide and direct care supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

Page 18

STAFFING RATIO REPORT FOR SECURE WARD STAFF

Only the secure ward staff and supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

CHART OF ACCOUNTS

RESIDENT REVENUES

The Private Resident, Other Governmental Supported Resident, and Medicaid Resident revenue accounts are for routine care charges. Revenues generated by charges for ancillary services and supplies are to be included in one of the other appropriate revenue accounts.

Acct. 2120 - Private Resident - ICF/MR
This account includes revenues for routine services provided to private residents that come under the ICF/TIR classification as defined in Rule 461-17-600.

Acct. 2140 - Private Resident.- Other
This account includes revenues for routine services provided to private residents that do not come under the ICF/MR, skilled, or semi-skilled classifications. The classifications and amounts should be specified on Schedule A.

Acct. 2250 - Other Governmental Supported Resident
This account includes revenues for routine services from other governmental programs, such as VA. Programs and amounts should be specified on Schedule A.

Acct. 2320 - Medicaid Resident - ICF/MR
This account includes revenues for routine services provided to Medicaid residents that are classified as ICF/MR by the Division.

Acct. 2400 - Physical Therapy
This account includes revenue for ancillary physical therapy services, not provided as part of routine care.

Acct. 2410 - Speech Therapy
This account includes revenue for ancillary speech therapy services, not provided as part of routine care.

Acct. 2420 - Occupational Therapy
This account includes revenue for ancillary occupational therapy services. not provided as part of routine care.

Acct. 2500 - Nursing Supplies
This account includes revenue for nursing supplies not provided as part of routine care.

Acct. 2510 - Prescription Drugs
This account includes revenue for prescription drugs not provided as part of routine care.

Acct. 2520 - Laboratory
This account includes revenue for laboratory work, supplies and services, not provided as part of routine care.

Acct. 2530 - X-Ray
This account includes revenue for x-ray work, supplies, and Services not provided as part of routine care.

Acct. 2600 - Barber and Beauty Shop
This account includes revenue for barber and beauty services and supplies not provided as part of routine care.

Acct. 2610 - Personal Purchase Income
This account includes revenue from resident purchases of incidental items not accounted for in any other revenue account and not provided as part of routine care.

Acct. 2700 - Miscellaneous Resident Revenue
If revenue is included in this account, items and amounts are to be specified on Schedule A.

Other Revenue

The following accounts are to be used to record revenues not as likely to come directly from residents as the foregoing revenues.

Acct. 2800 - Grants
This account includes income from grants.

Acct. 2810 - Donations
This account includes income from donations.

Acct. 2820 - Interest Income
This account includes interest income generated by loans.

Acct. 2830 - Rental Income
This account includes revenue generated by rental of equipment and facilities.

Acct. 2840 - Staff and Guest Food Sales
This account includes revenue from sale of food to staff and guests.

Acct. 2850 - Concession Income
This account includes revenue from concession sales, including candy machines, soft drink machines, and cigarette machines.

Acct. 2900 - Miscellaneous Revenue
If revenue is included in this account, items and amounts are to be specified on Schedule A.

Base and Labor Costs

The following accounts are to be used to classify expenses.

Base Costs

These accounts are for costs other than salaries and certain consulting fees.

General & Administrative

Acct. 3310 - Office Supplies and Printing
All office supplies, printing, small equipment of an administrative use not requiring capitalization, postage, printed materials including manuals and educational materials are to be included in this account.

Acct. 3510 - Legal and Accounting
Legal fees applicable to the facility and attributable to resident care are to be included in this account. Retainer fees are not a specific resident related cost and shall be adjusted as non-allowable. Legal fees attributable to a specific resident shall also be adjusted as non-allowable. Accounting and bookkeeping expenses of a non-duplicatory nature including accounting related data processing costs are also to be included in this account.

Acct. 3520 - Management fees
Management fees as defined in Rule 461-17-895 are to be included in this account.

Acct. 3530 - Donated Services
Donated services by non-paid workers as defined in Rule 461-17-810 are to be included in this account. The account should show the actual expenses in Column 1. Adjustments and reclassifications to appropriate salary accounts shall be made in Column 3. Attach worksheet to show adjustments and reclassifications.

Acct. 3610 - Communications
Telephone and telegraph expenses are to be included in this account.

Acct. 3711 - Travel - Motor Vehicle - Medical
This account includes medically related costs attributable to vehicle operation for facility and resident care use only. Personal use shall be separated from this account as an adjustment. Other expenses of auto insurance, repairs and maintenance, gas and oil, and reimbursement of actual employee expenses attributable to facility business should be included in this account. Auto allowances that are not documented by actual expenses will be reclassified to the appropriate salary or payroll account or adjusted as a non-allowable expense.

Acct. 3712 - Travel - Motor Vehicle - Non-Medical
This account includes the same kinds of costs described for Acct. 3711, Travel – Motor Vehicle - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

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Acct. 3721 - Travel - Other - Medical
This account includes all medically related travel expenses not related to the use of a vehicle belonging to the facility or an employee, including board and room on business trips, airline and bus tickets. These expenses should be attributable to and related to resident care or this account should be adjusted for expenses attributable to non-resident care travel.

Acct. 3722 - Travel - Other - Non-Medical
This account includes the same kinds of costs described for Acct. 3721, Travel - Other - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

Acct. 3809 - Other Interest Expense
Only interest not related to purchase of facility and equipment (including vehicles) is to be included in this account.

Acct. 3810 - Advertising and Public Relations
Advertising and public relations expenses are to be included in this account. See Rule 461-17-910 for definition of non-allowable portion.

Acct. 3320 - Licenses and Dues
License and dues expenses are to be included in this account.

Acct. 3830 - Bad Debts
Bad debts associated with Title XIX recipients are allowable. All other bad debts shall be adjusted as non-allowable.

Acct. 3840 - Freight
This account includes shipping charges paid by the provider, unless they should be capitalized as part of a capital asset.

Acct. 3910 - Miscellaneous
This account includes general and administrative expenses not otherwise includable in the General and Administrative Cost Area. These expenses are to be described on Schedule A.

Shelter

Acct. 4310 - Repair and Maintenance
This account contains all material costs entailed in the maintenance and repair of the building and departmental equipment.

Acct. 4510 - Purchased Services
This account contains all expenses paid for outside services purchased in the maintenance and repair of building, building equipment and department equipment. It is also to include items such as lawn care by an outside service, security service, etc.

Acct. 4610 - Real Estate and Personal Property Taxes
Real estate and personal property tax expenses are to be included in this account.

Acct. 4620 - Rent
Rent attributable to the lease of a facility is to be included in this account.

Acct. 4630 - Lease
Lease expenses of equipment, vehicles, and other items separate from rent of a facility are to be included in this account.

Acct. 4640 - Insurance
This account includes all insurance expenses except auto insurance, which should be classified under Travel - Motor Vehicle.

Acct. 4710 - Depreciation - Land-Improvements
See Rules regarding capital assets and depreciation.

Acct. 4720 - Depreciation - Building
See Rules regarding capital assets and depreciation.

Acct. 4730 - Depreciation -Building Equipment
See Rules regarding capital assets and depreciation.

Acct. 4740 - Depreciation -Moveable Equipment
See Rules regarding capital assets and depreciation.

Acct. 4750 - Depreciation -Leasehold Improvements
See Rules regarding capital assets and depreciation.

Acct. 4809 - Interest
Interest attributable to the purchase of facility and equipment is to be included in this account.

Acct. 4910 - Miscellaneous
This account includes shelter expenses not otherwise includable in the Shelter Cost Area.

Utilities

Acct. 5610 - Heating Oil
Heating oil expense is to be included in this account.

Acct. 5620 - Gas
Gasoline for autos included in Travel - Motor Vehicles.

Acct. 5630 - Electricity
Electricity expense is to be included in this account.

Acct. 5640 - Water, Sewage and Garbage
Water, sewage and garbage expenses are to be included in this account.

Laundry

Acct. 6310 - Laundry Supplies
Laundry supplies expense is to be included in this account.

Acct. 6315 - Linen and Bedding
Linen and bedding expense is to be included in this account.

Acct. 6510 - Purchased Laundry Services
Laundry services purchased from an outside provider are to be included in this account.

Acct. 6910 - Miscellaneous
This account includes laundry costs not otherwise includable in the Laundry Cost Area.

Housekeeping

Acct. 7310 - Housekeeping Supplies
Housekeeping supplies expense is to be included in this account.

Acct. 7910 -Miscellaneous
This account includes housekeeping costs not otherwise includable in the Housekeeping Cost Area.

Dietary

Acct. 8310 - Dietary Supplies
This account includes expenses associated with the serving of food, such as utensils, paper goods, dishware and other items.

Acct. 8410 - Food
This account combines all the costs of prepared foods, meats, vegetables and all manner of food ingredients and supplements. Expenses for candy, food or beverages sold through vending machines, commissary or snack-bar are to be included in the expense account Concession Supplies.

Acct. 8910 - Miscellaneous
This account includes dietary costs not otherwise includable in the Dietary Cost Area.

Nursing Supplies and Services

Acct. 9310 - Nursing Supplies
This account includes costs of supplies used in nursing care covered in Rule 461-17-650 (3).

Acct. 9320 - Drugs and Pharmaceuticals Non-RX
This account includes costs of drugs and pharmaceuticals defined in Rule 461-17-650 (2) (f).

Acct. 9330 - Drugs and Pharmaceuticals - RX
This account includes drug prescription costs defined in Rule 461-17-655(1).

Acct. 9351 - Pharmacy Services and Supplies
Pharmacy supplies and outside services expenses are to be included in this account.

Acct. 9352 - Laboratory Services and Supplies
Laboratory supplies and outside services expenses are to be included in this account.

Acct. 9353 - X-Ray Services and Supplies
X-Ray supplies and outside services expenses are to be included in this account.

Acct. 9354 - Recreation Supplies and Services
Activities supplies and outside services expenses are to be included in this account.

Acct. 9355 - Rehabilitation Supplies and Services
Rehabilitation supplies and outside services expense are to be included in this account.

Acct. 9510 - Physician Fees
Outside physician fees are to be included in this account.

Acct. 9530 - Day Treatment Supplies and Services
Only FSRTF facilities are to use this account, which is to include day treatment supplies and services expense.

Acct. 9950 - Concession Supplies
This account includes costs associated with vending machines and similar resale items.

Acct. 9955 - Barber and Beauty Shop
This account includes barber and beauty related costs. Costs of services and supplies not meeting the definition in Rule 461-17-650(2)(g) shall be adjusted.

Acct. 9960 - Funeral and Cemetery
Funeral and cemetery expenses are to be included in this account.

Acct. 9965 - Personal Purchases
This account includes the costs of all items purchased for resident care and excluded in Rule 461-17-650 as part of the all-inclusive rate unless specifically included in another account. These items would include, but not be limited to, incidental items defined in Rule 461-17-660 authorized for payment from resident funds, and items not routinely furnished to all residents without additional costs.

Acct. 9990 - Miscellaneous
This account includes miscellaneous supplies and services not otherwise includable in the Nursing Supplies and Services Cost Area. Items and amounts are to be listed on Schedule A.

Labor Cost

Payroll Taxes and Employee Benefits

These accounts are to include all payroll taxes and employee benefits. The total net allowable payroll taxes and employee benefits (Acct. #3200) are to be allocated to the appropriate payroll and employee benefit account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

Acct, 3200 - Total Employee Benefits & Taxes
This account is the total of Acct. 3210 Total Payroll Taxes and Acct. 3220 Employee Benefits.

Acct. 3210 - Total Payroll Taxes
This account includes the payroll taxes FICA, Acct. 3211, State Unemployment, Acct. 32l2, Federal Unemployment, Acct. 3213, Workers' Compensation, Acct. 3214, Tri-Met, Acct. 3215, and any others.

Acct. 3211 - FICA
This account includes the FICA tax.

Acct. 3212 - State Unemployment
This account includes the State unemployment insurance tax.

Acct. 3213 - Federal Unemployment
This account includes the Federal unemployment insurance tax.

Acct. 3214 - Worker’s Compensation
This account includes the Worker’s Compensation tax.

Acct. 3215 - Tri-Met
This account includes the Tri-Met payroll tax.

Acct. 3216 - Payroll Tax - Other
Any amount showing in this account must be identified.

Acct. 3220 - Employee Benefits
This account includes all employee benefits, and does not include payroll taxes for unemployment insurance and state accident insurance.

Administrative Salaries

Acct. 3110 - Administrator Salary
This account includes all of the compensation received by the administrator. Other compensation including allowances and benefits not documented by specific costs, or similarly accruing to other employees of the facility are to be included in this account as a reclassification.

Acct. 3231 - Employee Benefits & Taxes
This account includes employee taxes and benefits for the administrator, including employee insurance, vacation and sick pay, and other fringe benefits not otherwise accounted for. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other - Administrative Salaries

Acct. 3120 - Assistant Administrator Salary
This account includes all compensation received by the assistant administrator. The provisions applicable to the administrator compensation apply.

Acct. 3130 - Salaries - Other Administrative
All clerical, receptionist, ward clerk and medical records personnel salaries are to be included in this account. All home office payroll allocable to the facility is to be included in this account unless it is adequately demonstrated on an attachment to the cost statement that payroll amounts belong in another payroll account.

Acct. 3232 - Employee Benefits and Taxes
This account includes benefits and taxes for the other administrative personnel. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Nursing Salaries

Acct. 9110 - Salaries - DNS
Director of Nursing Service salary is to be included in this account.

Acct. 9111 - Salaries - RN
Registered Nurse salaries are to be included in this account.

Acct. 9112 - Salaries - LPN
Licensed Practical Nurse and Licensed Vocational Nurse salaries are to be included in this account.

Acct. 9291 - Employee Benefits and Taxes
This account shall include employee benefits and taxes for the DNS, RN's, and LPN's. The costs are to be allocated from Acct #3200 - Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Direct Care Salaries

Acct. 9122 - Salaries - Direct Care
Salaries for the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills are included in this account. This does not include salaries for other professional services included under active treatment services.

Acct. 9123 - Salaries - Direct Care Supervisors
Salaries for direct care supervisors.

Acct. 9124 - Salaries - Secure Ward Staff
Salaries for secure ward staff.

Acct. 9125 - Salaries - Secure Ward Supervisors
Salaries for secure ward supervisors.

Acct. 9292 - Employee Benefits and Taxes
This account includes employee benefits and taxes for direct care staff.
The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other Salaries

Acct. 4110 - Repair and Maintenance Salaries
This account includes payroll for services related to repair, maintenance and plant operation.

Acct. 6110 - Laundry Salaries
Laundry salaries are to be included in this account.

Acct. 7110 - Housekeeping Salaries
Janitorial salaries and housekeeping salaries are to be included in this account.

Acct. 8110 - Dietary Salaries
Dietary salaries are to be included in this account.

Acct. 9130 - Salaries - Physician
Physician salaries, exclusive of physician fees and consulting services, are to be included in this account.

Acct. 9131 - Salaries - Pharmacy
Pharmacy salaries are to be included in this account.

Acct. 9132 - Salaries - Laboratory
Laboratory salaries are to be included in this account.

Acct. 9133 - Salaries - X-Ray
X-ray salaries are to be included in this account.

Acct. 9134 - Salaries - Activities (Occupational)
Activities (occupational) salaries are to be included in this account.

Acct. 9135 - Salaries - Rehabilitation
Rehabilitation salaries are to be placed in this account.

Acct. 9140 - Salaries - Religious
Relig4ous salaries are to be included in this account.

Acct. 9148 - Salaries - Receiving Warehouse
Only receiving warehouse salaries incurred by FSRTF's are to be included in this account.

Acct. 9149 - Salaries - Other
This account includes Nursing Service Salaries not otherwise includable in the Nursing Service Cost Area. Purchased nursing services are to also be included in this account. Items and amounts are to be specified on Schedule A.

Acct. 9296 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees listed in the cost category. The costs are to be allocated from Acct. #3200 Total Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Active Treatment Services

These accounts include all special programs, except Day Program service costs incurred by FSRTF'S, and professional medical services, except Medical Service costs incurred by FSRTF'S. Included are costs for consultation, treatment and evaluations not paid for separately by the Division. Expenses not required for certification shall be adjusted as non-allowable.

Acct. 9150 - Qualified Mental Retardation Professional
Acct. 9151 - Registered Nurse Consultant (SRTF Only)
Acct. 9152 - Psychologist
Acct. 9153 - Social Worker
Acct 9154 - Speech Therapist
Acct. 9156 - Occupational Therapist
Acct. 9157 - Recreation Therapist
Acct. 9158 - Physical Therapist
Acct. 9159 - Dietitian
Acct. 9160 - Dentist
Acct. 9161 - Pharmacist
Acct. 9162 - Skill Trainer/Program Coordinator
Acct. 9170 - Other Medical Consultants
Acct. 9297 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Medical Services

These accounts include only medical service program costs incurred by FSRTF's.

Acct. 9180 - Physician Services
Acct. 9181 - Pharmacy Services
Acct. 9182 - Laboratory Services
Acct. 9183 - X-Ray Services
Acct. 9186 - Nursing Services
Acct. 9187 - Dental Services

Acct. 9188 - Central Supply Services

Acct. 9298 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Day Program Services

These accounts include only Day Program service costs incurred by FSRTF'S.

Acct. 9190 - Day Program Services

Acct. 9299 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

ICF/MR COST STATEMENT

NAME ON LICENSE_____PROVIDER NO. MS

MAILING ADDRESS

STREET ADDRESS _____AFS BRANCH

CITY, STATE, ZIP _____ PHONE

ACCOUNTING AND OTHER DATA

PERIOD OF THIS REPORT: FROM _____ THROUGH

NUMBER OF DAYS IN ABOVE PERIOD _____ENDING MONTH OF NORMAL/FISCAL YEAR _____

TYPE OF ORGANIZATION: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ PROPRIETARY CORPORATION

☐ NON-PROFIT CORPORATION ☐ OTHER: _____

NAME OF HOME OFFICE, IF ANY

ADDRESS_____PHONE

ACCOUNTANT'S NAME AND/OR FIRM NAME

ADDRESS_____PHONE

THE BOOKS ARE KEPT AT:

PUBLIC BILLING RATES

DURING THE TIME PERIOD COVERED BY THIS COST STATEMENT, THE RATES THAT WE CHARGED OUR PRIVATE RESIDENTS FOR ICF/MR SERVICES WERE:

INCLUSIVE DATES	CLASSIFICATION UNDER WHICH RATES WERE CHARGED* #1	#2	#3	#4	#5	#6

*Submit an appropriate definition of each classification on a separate schedule and submit a copy with this cost report.

This cost statement has been prepared from information furnished without independent examination by me (us). Since my (our) procedures did not constitute an examination made in accordance with generally accepted auditing standards, I (we) do not express an opinion on these statements.

_____ _____
Title Date

Under penalties of law, I declare that I have examined this cost statement, including accompanying schedules and statements, and that this material is complete, accurate and true and prepared in accordance with the rules of the Adult and Family Services Division of the State of Oregon. I understand that any false statement, claim or document or concealment of material fact herein may be prosecuted under applicable federal or state law.

TN# 80-31 Date Approved: 1/20/81
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IDENTIFICATION OF OWNERS, PARTNERS, LESSEES, STOCKHOLDERS, ETC., WITH 5% OR MORE OWNERSHIP IN THIS FACILITY

NAME	TITLE	RESIDENCE (CITY & STATE	%
			100

COMPENSATION OF OWNERS, PARTNERS, FAMILY MEMBERS, RELATIVES, LESSEES, STOCKHOLDERS, OFFICERS

	NAME	RELATIONSHIP	SERVICE(S) PERFORMED
1			
2			
3			
4			
5			

	% of customary work week devoted to this facility business	Compensation amount included in this cost statement (omit ¢)	Account number(s) where compensation is included
1A			
2A			
3A			
4A			
5A			

OTHER FACILITIES/BUSINESSES FOR WHICH THE OWNERS EXERCISE A 5% OR MORE OWNERSHIP OR CONTROL

OWNER NAME	FACILITY/BUSINESS NAME	%	NATURE OF BUSINESS

ADMINISTRATOR SUMMARY

NAME	DATE OF SERVICE
	Current Administrator

RELATED ORGANIZATIONS*
(*Defined in Rule 461-17-600 of the ICF/MR-Provider Guide)

NAME	DESCRIPTION OF SERVICES, FACILITIES, AND SUPPLIES	NATURE OF RELATIONSHIP

Cost of goods or services to the related organization and charge to the facility shall be listed by account on Schedule A.

SPECIAL NOTES PERTAINING TO COST STATEMENT

DATA ON FACILITIES & EQUIPMENT

1 DATE THIS FACILITY ACQUIRED _____ APPROXIMATE AGE OF FACILITY

2 LAND&BUILDING: __OWNED __LEASED EQUIPMENT: __OWNED _LEASED

IF LEASED, LESSOR'S NAME & ADDRESS:
_____
_____
_____

IF LEASED, LESSOR'S NAME & ADDRESS:
_____
_____
_____

4 A COPY OF THE FACILITY LEASE, INCLUDING AMENDMENTS, PLUS A COPY OF YOUR FEDERAL OR OTHER APPLICABLE DEPRECIATION SCHEDULES ARE REQUIRED.
5 REASON IF FACILITY LEASE NOT ATTACHED _____
6 REASON IF DEPRECIATION SCHEDULE NOT ATTACHED

REVENUE

ACCOUNT #	ACCOUNT	(1) + FACILITY GROSS REVENUE	(2) + HOME OFFICE REVENUE	(3) ADJ. & RECLASS.	= (4) NET PROVIDER REVENUE
RESIDENT REVENUES					
2120	Private Resident ICF/MR				
2140	Private Resident-Other (Sch. A)				
2250	Other Governmental Supported Resident (Sch.A)				
2320	Medicaid Resident - ICF/MR				
2400	Physical Therapy				
2410	Speech Therapy				
2420	Occupational Therapy				
2500	Nursing Supplies				
2510	Prescription Drugs				
2520	Laboratory				
2530	X-Ray				
2600	Barber & Beauty Shop				
2610	Personal Purchase Income				
2700	Miscellaneous Resident Revenue (Sch. A)				
OTHER REVENUE					
2800	Grants				
2810	Donations				
2820	Interest Income				
2830	Rental Income - Facilities & Equip.				
2840	Staff & Guest Food Sales				
2850	Concession Income				
2900	Miscellaneous Revenue (Sch. A)				
	TOTAL REVENUES				

Net Income per ICF/MR Cost Statement
Net Income per IRS Report _____

Difference if any (Reconcile on Sch. A) _____

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SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
GENERAL & ADMINISTRATIVE					
3310	Office Supplies & Printing				
3510	Legal & Accounting				
3520	Management Fees				
3530	Donated Services				
3610	Communications				
3711	Travel-Motor Vehicle-Medical				
3712	Travel-Motor Vehicle-Non-Medical				
3721	Travel-Other-Medical				
3722	Travel-Other-Non-Medical				
3809	Other Interest Expense				
3810	Advertising & Public Relations				
3820	Licenses & Dues				
3830	Bad Debts				
3840	Freight				
3910	Miscellaneous (Sch. A)				
	TOTAL GENERAL & ADMINISTRATIVE				
SHELTER					
4310	Repair & Maintenance Supplies				
4510	Purchased Services				
4610	Real Estate & Personal Property Taxes				
4620	Rent				
4630	Lease				
4640	Insurance				
4710	Depreciation-Land Improvements				
4720	Depreciation-Building				
4730	Depreciation-Bldg. Equip				
4740	Depreciation-Moveable Equip.				
4750	Depreciation-Leasehold Improvements				
4809	Interest				
4910	Miscellaneous (Sch. A)				
	TOTAL SHELTER				
UTILITIES					
5610	Heating Oil				
5620	Gas				
5630	Electricity				
5640	Water, Sewage & Garbage				
	TOTAL UTILITIES				

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SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
LAUNDRY					
6310	Laundry Supplies				
6315	Linen & Bedding				
6510	Purchased Laundry Services				
6910	Miscellaneous (Sch. A)				
	TOTAL LAUNDRY				
HOUSEKEEPING					
7310	Housekeeping Supplies				
7910	Miscellaneous (Sch. A)				
	TOTAL HOUSEKEEPING				
DIETARY					
8310	Dietary Supplies				
8410	Food				
8910	Miscellaneous (Sch. A)				
	TOTAL DIETARY				
NURSING SUPPLIES & SERVICES					
9310	Nursing Supplies				
9320	Drugs & Pharmaceuticals Non-Prescription				
9330	Drugs & Pharmaceutical Prescription Drugs				
9351	Pharmacy Services & Supplies				
9352	Lab Services & Supplies				
9353	X-Ray Services & Supplies				
9354	Recreational Supplies Services				
9355	Rehabilitation Supplies & Services				
9510	Physician Fees				
9530	Day Treatment Supplies & Services (FSRTF Only)				
9950	Concession Supplies				
9955	Barber & Beauty Shop				
9960	Funeral & Cemetery				
9965	Personal Purchases				
9990	Miscellaneous (Sch. A)				
	TOTAL NURSING SUPPLIES & SERVICES				
	TOTAL BASE COSTS				

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SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+(2) + HOME OFFICE EXPENSE	(3) = ADJUSTMENTS AND RECLASSIFICATION	(4) NET ALLOWABLE EXPENSES
ADMINISTRATOR SALARIES					
3110	Administrator Salary				
3231	Employee Benefits & Taxes				
	TOTAL				
OTHER ADMINISTRATIVE SALARIES					
3120	Salary-Ass't. Administrator				
3130	Salaries-Other Admin.				
3232	Employee Benefits & Taxes				
	TOTAL				
NURSING SALARIES					
9110	Salaries-DNS				
9111	Salaries-RN				
9112	Salaries-LPN				
9291	Employee Benefits & Taxes				
	TOTAL				
DIRECT CARE SALARIES					
9122	Salaries-Direct Care Staff				
9123	Salaries-Direct Care Supervisors				
9l24	Salaries-Secure Ward Staff				
9125	Salaries-Secure Ward Supervisors				
9292	Employee Benefits &Taxes				
	TOTAL				
OTHER SALARIES					
4110	Repair & Maintenance Salaries				
6110	Laundry Salaries				
7110	Housekeeping Salaries				
8110	Dietary Salaries				
9130	Salaries-Physician				
9131	Salaries-Pharmacy				
9132	Salaries-Laboratory				
9133	Salaries-X-Ray				
9134	Salaries-Activities (Occupational)				
9135	Salaries-Rehabilitation				
9140	Salaries-Religious				
9148	Salaries-Receiving Warehouse (FSRTF only)				
9149	Salaries-Other (Sch. A)				
9296	Employee Benefits & Taxes;				
	TOTAL				

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SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
ACTIVE TREATMENT SERVICES					
9150	Qualified Mental Retardation Professional				
9151	Registered Nurse Consultant (SRTF Only)				
9152	Psychologist				
9153	Social Worker				
9154	Speech Therapist				
9156	Occupational Therapist				
9157	Recreational Therapist				
9158	Physical Therapist				
9159	Dietitian				
9160	Dentist				
9161	Pharmacist				
9162	Skill Trainer/Program Coord.				
9170	Other Medical Consultants (Sch. A)				
9297	Employee Benefits & Taxes				
	TOTAL				
MEDICAL SERVICES (FSRTF only)					
9180	Physician Services				
9181	Pharmacy Services				
9182	Laboratory Services				
9183	X-Ray Services				
9186	Nursing Services				
9187	Dental Services				
9188	Central Supply Services				
9298	Employee Benefits & Taxes				
	TOTAL				
DAY PROGRAM SERVICES (FSRTF only)					
9190	Day Program Services				
9299	Employee Benefits & Taxes				
	TOTAL				
	TOTAL LABOR COSTS				
	TOTAL BASE & LABOR COSTS				

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SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
3211	FICA				
3212	State Unemployment				
3213	Federal Unemployment				
3214	Worker's Compensation				
3215	Tri-Met				
3216	Other (Specify)				
3210	TOTAL PAYROLL TAXES				
3200	TOTAL EMPLOYEE BENEFITS & TAXES				

NOTE: The net allowable payroll taxes and employee benefits (column 4 above) are to be allocated to the appropriate sub-accounts in each "Labor Cost" category by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON OWNER'S EQUITY CALCUIATION

_____ Net Owner's Equity at Beginning of Period

_____ Net Owner's Equity at End of Period

_____ + 2 = _____ Average Owner's Equity

x _____ Rate of Return

=_____ Return on Owner's Equity

Note: The return on owner's equity is entered on Page 12, or, if an allocation is required, on Page 13.

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BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+ (2) HOME OFFICE	+ (3) ADJ. & RECLASS.	= (4) NET
1101	Cash on Hand				
1102	Cash in Bank				
1103	Cash in Savings				
1150	Accounts Receivable				
1160	Notes Receivable				
1169	Provision for Doubtful Accounts				
1170	Employee Advances				
1200	Inventory-Nursing Supplies				
1201	Inventory-Food				
1202	Inventory-Other				
1250	Prepaid Expenses (Sch. A)				
1270	Other Current Assets (Sch. A)				
1310	Land				
1320	Land Improvements				
1321	Accumulated Depreciation Land Improvements				
1330	Buildings				
1331	Accumulated Depreciation-Bldg.				
1340	Equipment-Bldg. Fixed				
1341	Accumulated Depreciation-Equip. Bldg.				
1350	Equipment-Moveable				
1351	Accumulated Depreciation - Equip. Moveable				
1370	Leasehold Improvements				
1371	Accumulated Amortization-Lease Improvements				
1400	Investments (Sch. A)				
1470	Other L/T Assets (Sch. A)				
	TOTAL ASSETS				

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BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+	(2) HOME OFFICE	+	(3) ADJ. & RECLASS.	=	(4) NET
LIABILITIES AND CAPITAL								
1510	Accounts Payable							
1550	Notes Payable-Other							
1560	Notes Payable - Owners							
1570	Accrued Interest Payable							
1600	Payroll Payable							
1610	Payroll Taxes Payable							
1620	Other Payroll Deductions Payable							
1630	Deferred Income (Sch. A)							
1670	Other Current Liabilities (Sch. A)							
1810	Long-Term Mortgage Payable -							
1850	Long-Term Notes Payable - Other							
1860	Long-Term Notes Payable - Owners							
1870	Other Long-Term Liabilities (Sch. A)							
	TOTAL LIABILITIES							
1910	Capital Stock							
1950	Retained Earnings							
1960	Capital Account - Proprietor or Partners							
1970	Drawing Account - Proprietor or Partners							
1980	Net Profit (loss) year to date							
	TOTAL CAPITAL							
	TOTAL LIABILITIES & CAPITAL							

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COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES WITH OTHER REVENUE PRODUCING PROGRAMS

If there is no revenue producing activity related to non-allowable costs which generates revenue in excess of 2% of the total gross expenses, check here do not complete this page, and continue with the next page.
If a different allocation method is used, an explanation of the method and the reason for its use must be provided on page 4.
Each level-of-care column should contain the resident days or square feet related to that level-of-care as designated in each cost area.
For each cost area, the allocation base is the total of the level-of-care columns for that cost area.
The multiplier is the net cost area expense divided by the allocation base.
The product of the multiplier and the ICF/MR Level-of-Care column by cost area is entered on the "Allocated Costs" schedule on page 14.

COST AREA/ DESIGNATED ALLOCATION METHOD	Level-of-Care ICF/MR	Level-of-Care Other (Specify)	Level-of-Care Other (Specify)	Allocation Base	Net Cost Area Expense	Multiplier
Gen. & Admin. Resident Days						
Shelter Square Footage						
Utilities Square Footage						
Laundry Resident Days						
Housekeeping Square Footage						
Dietary Resident Days						
Nursing Supplies & Services Resident Days						
Admin. Salaries Resident Days						
Other Admin. Salaries Resident Days						
Nursing Salaries Actual Payroll						
Direct Care Salaries Actual Payroll						
Other Salaries Actual Payroll						
Active Treatment Services						

__Actual Payroll
Medical Services
__Actual Payroll
Day Program Services
__Actual Payroll
Return on Equity
__Resident Days

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ALLOCATED COSTS

Cost Areas	ICF/MR
BASE COSTS	
General & Administrative	
Shelter	
Utilities	
Laundry	
Housekeeping	
Dietary	
Nursing Supplies & Services	
TOTAL BASE COSTS	
LABOR COSTS	
Administrator Salaries	
Other Administrative Salaries	
Nursing Salaries	
Direct Care Salaries	
Other Salaries	
Active Treatment Services	
Medical Services	
Day Program Services	
TOTAL LABOR COSTS	
RETURN ON EQUITY	
GRAND TOTAL	

GRAND TOTAL = _____ ICF/MR Cost per Day
ICF/MR Resident Days

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SCHEDULE A

EXPLANATION OF MISCELLANEOUS ACCOUNTS

ACCT. #	EXPLANATION	AMOUNT	ACCT. #	EXPLANATION	AMOUNT

Resident Classification Report
Resident Days By Classification and B Level-Of-Care

Month ICF/MR

	A		A-I-3		S		B		C		TOTAL	Other (Specify)
	AFS	Other	AFS	Other	AFS	Other	AFS	Other	AFS	Other		
January												
February												
March												
April												
May												
June												
July												
August												
Sept.												
October												
Nov.												
Dec.												
TOTAL												

Month Resident Days by licensed Bed

	Designated ICF/MR Area			Other (Specify)	Other (Specify)
	AFS	Other	Total		
January					
February					
March					
May					
June					
July					
August					
Sept.					
October					
Nov.					
Dec					
TOTAL					

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Bed Capacity

	Designated ICF/MR Area			Other (Specify)			Other (Specify)		
	Beginning	Change	Change	Beginning	Change	Change	Beginning	Change	Change
Licensed Bed Capacity									
Certificate of Need Capacity									
Available Capacity									
Date Changed									

STAFFING RATIO REPORT OR DIRECT CARE STAFF*

	SHIFT									
	1st				2nd				3rd	
MONTH	No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs Worked	
	Staffs	Sups.	Staff	Sups.	Staff	Sups.	Staff.	Sups	Staff	Sups.	Staff	Sups.
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												

*Direct Care Staff - See ICF/MR Provider Guide for Definition.

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STAFFING RATIO REPORT FOR SECURE WARD STAFF

	SHIFT									
	1st				2nd				3rd	
	No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward	No. of Hrs Worked
	Staffs	Sups.	Staff	Sups.	Staff	Sups.	Staff.	Sups	Staff Sups.	Staff Sups.
January										
February										
March										
April										
May										
June										
July										
August										
September										
October										
November										
December										

DEFINITION OF A CLAIM

(1) For nursing facility services (SNF, ICF, ICF/HA, ICF-MR) and state mental hospital services (MI) and non-ancillary charges for private psychiatric hospital services, a claim is a line item on the invoice (AFS 403).

(2) For all other services, a claim is an invoice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: OREGON

Requirements for Third Party Liability -
Identifying Liable Resources

(1) The requirements in 433.138(f) is met, as follows:

A. The frequency of the data exchange with the Employment Division (SWICA) is quarterly.

B. The frequency of the data exchange with Title IV-A is daily.

C. The frequency of the data exchange with the Motor Vehicle Division for accident report data is monthly.

D. The frequency of diagnosis and trauma code edits is daily.

E. The frequency of the data exchange with Worker's Compensation is monthly.

(2) The requirement in 433.138(g)(1)(ii) is met, as follows:

A. SWICA

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds $450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and to gather health insurance information.

For wages paid on or after January 1, 1990, employers in Oregon are required to furnish the Employment Division with information about health insurance coverage offered to employees or to their dependents. The Employment Division will gather the information and pass it to the Adult and Family Services Division on a quarterly basis. The IV-D Agency will develop the medical insurance information as part of the medical support enforcement activities and will pass the information to the Title XIX Agency.

B. Title IV-A

Health insurance information is passed to the Title XIX Agency via the AFS 415H form on a daily basis. Health insurance information is gathered, but not limited to, initial application and each redetermination.

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds $450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow- up. These forms are used to verify earnings and gather health insurance information.

On a monthly basis, a match is made with the health insurance codes on the CMS system and the third party resources on the MMIS TPR file. A report is generated when there is a discrepancy so that the correct resource information is available for processing claims.

(3) The requirement in 433.138(g)(2)(ii) is met, as follows:

A. Health Insurance

Adult and Family Services Division (AFS), Children's Services Division (CSD), and Senior and Disabled Services Division (SDSD) employees and Type B AAA contractors of SDSD obtain health insurance information from applicants for and recipients of Medicaid. Such information is gathered during the initial application for assistance and at each subsequent redetermination of eligibility, or at any other time that new information becomes known. Information may include, but is not limited to, the policy holder's name and social security number, the group or plan number, the policy or identification number, and the name and address of the insurance company.

Eligibility staff in branch offices of these Divisions and in Type B AAA offices are responsible for assuring that all available information is recorded on Form AFS 415H, and for sending a copy of the completed form to the Third Party Recovery Unit of the AFS Recovery services Section. The branch office retains the original AFS 415H in the client's case record file.

Third Party Recovery Unit staff verify the information on the AFS 415H and then enter the information onto the MMIS Recipient Subsystem, Third Party Resource File. If the branch enters a Medicare health insurance code (HIC) on the eligibility file, the Medicare insurance information is electronically transferred to the Third Party Resource file on MMIS.

Health insurance information may also be identified by AFS State office staff, through such sources as the Title IV-D Child Support Program, BENDEX, or provider billings or refunds that indicate health insurance. In such cases, Third Party Recovery Unit staff obtain all available information, complete the AFS 41SH (and send the original to the branch office), and code the information onto the MMIS Third Party Resource file. The Buy-In Unit verifies the electronically transferred Medicare insurance on the TPR file.

The MMIS System uses the health insurance information in processing claims, in accordance with 433.139(b) through (f). Health insurance information is also entered onto the client's medical identification card.

MMIS generates a monthly report (WMMR026R-A) to the Third Party Recovery Unit for review of recovery potential whenever new insurance is added and whenever there is a change in the effective date of known insurance.

The time frame for completing this process, from the date that Division staff first discover health insurance information until the information appears on Report #WMMRO26R-A, is 60 days.

The written agreement between AFS and SDSD provides that SDSD will collect health insurance information and transmit this information to AFS.

The written agreement between AFS and CSD provides that CSD will collect health insurance information and transmit this information to AFS.

B. Worker's Compensation

Oregon's Medicaid program is in the process of implementing a data exchange with Workers' Compensation. Once this match is implemented, we will update this item.

During the implementation of this data match, we will use the data match that provides employment-related health insurance as described in section II-A above, In addition, the IV-D agency will continue to conduct a data match with Workers' Compensation and perform medical support enforcement activities involving the absent parents.

(4) The requirement in 433.138(g)(3)(i) is met, as follows:

A. Motor Vehicle Accident Report data match

The Department of Motor Vehicles provides a monthly transaction tape containing motor vehicle accident report information. These transactions are matched with clients on the MMIS Recipient file by name and date of birth. Clients with an eligibility period on or after the date of the accident are matched. The matches are then run by the Expense Avoidance file and any record that has already been followed-up will be eliminated to avoid duplication of effort.

Information from the DMV transaction tape and from MMIS will be downloaded from the mainframe to a floppy disk. The floppy disk is loaded into the Third Party Recovery Unit's DMV Accident Data Base File on a personal computer. This data base is used for generating letters and is used for tickler purposes. The follow-up steps are as follows:

a) The Third Party Recovery Unit sends a letter to each client, asking for information about the accident. An AFS 451 is sent with each letter. This is the form that clients use to report motor vehicle accident information. The data base is updated when the response is received and serves as the tickler file to keep track of those situations where no response is received within the initial 30 days.

b) If no response is received within 30 days, a follow-up letter to the recipient is generated from the data base.

c) If no response is received within 30 days of the second letter, the Third Party Recovery unit obtains a copy of the accident report from the Division of Motor Vehicles.

(5) The requirement in 433.138(g)(3)(iii) is met, as follows:

A. Motor Vehicle Accident Report data match

After follow-up, all information that identifies legally liable third party resources is entered by staff from the Third Party Recovery Unit on the MMIS Third Party Resource File or the MMI-S Expense Avoidance File; The MMIS System automatically enters an indicator in the appropriate field on the MMIS Recipient File. The time frame for incorporating the information is 60 days.

(6) The requirement in 433.138(g)(4)(i) is met, as follows:

Claims which meet the following edit criteria are suspended on a daily basis:

Through MMIS edit 417, a report is generated for claims that contain diagnosis codes 800 through 999, with the exception of code 994.6. This edit reports all impatient hospital claims where the billed amount exceeds zero, and outpatient hospital and medical claims where the billed amount exceeds $250 dollars.

Edit 406 will suspend claims which indicate auto related, with no form AFS 451 information on the Expense Avoidance file.

1) A worksheet/report is generated and is sent to the Third Party Recovery Unit. The worksheets are reviewed, with priority given to the following:

A. Claims with auto accident indicators.

B. Claims with the following diagnosis codes: 810.00, 815.03, 821.00, 850.00, 922.10, and 997.30.

This sub-group of diagnosis codes represents injuries most likely to yield recoveries based on prior experience. On an annual basis the Third Party Recovery Unit will review the related trauma diagnosis codes for medical recoveries which exceed $5000, to determine which trauma diagnosis codes should receive the highest priority for follow-up activities for the following year.

C. Claims containing diagnosis codes beginning with E, unless such claims clearly do not represent a liability situation.

D. Claims exceeding $10,000, which are not related to late effects of surgery, unless such claims clearly do not represent a liability situation.

The Third Party Recovery Unit follows-up all claims included in A -D above, with written correspondence to the client. The client is provided with an AFS 451/AFS 451NV form to complete. The AFS 451/AFS 451NV are used to report accident information to the agency. If no response is received within 30 days, a second letter is sent to the client. If there is no current address for the client, a memo is sent to the branch worker requesting assistance. on a case by case basis, information may be obtained from the medical provider.

The completed AFS 451/AFS 451NV form is reviewed by the Third Party Recovery Unit. Liens are filed in liability situations and the information incorporated into the MMIS Expense Avoidance File. In addition to lienable situations, all claims suspended are reviewed for possible other insurance. All third party resource information identified is incorporated into the MMIS third party data base files. The MMIS Recipient file is updated with an indicator whenever a Third Party Resource file or an Expense Avoidance file is created. The information is used by the MMIS system to process claims in accordance with 433.139(b) through (f).

(7) The requirement in 433.138(g)(4)(iii) is met, as follows:

After follow-up, all information that identifies legally liable third party resources is incorporated into the Third Party Recovery Unit, the MMIS Recipient File, and either the MMIS Expense Avoidance File or the MMIS Third Party Resource File, within 60 days.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Requirements for Third Party Liability -
Payment of Claims

1) The requirement in 433.139(b)(3)(ii)(C) is met, as follows:

Medical providers use a third party resource (TPR) explanation code on the claim to communicate that the service involves insurance through the absent parent in a IV-D enforcement case, and that 30 days have lapsed since the date of service, and that the provider has not received payment from the third party resource. The MMIS system will edit for the 30 day requirement. If less than 30 days have lapsed, the claim will be rejected.

On a quarterly basis, the MMIS system produces a listing of all claims processed for recipients with third party resource coverage. This report includes all claims with a TPR explanation code. This report is used by the Utilization Review group to identify any fraudulent or erroneous billings through verification with the third party carriers.

2) The requirement in 433.139(f)(2) is met, as follows:

Threshold amounts. With the implementation of the Post Payment Recovery System the threshold amount for the post payment recovery of claims are:

A) For claims involving Medicare, zero.

B) For claims involving private health insurance, zero.

C) For drug claims, $25.

D) For ICF/MR and IMD, zero.

E) For claims paid under the provisions of 433.139(b)(3), zero.

3) The requirement in 433.139(f)(3) is met, as follows:

A) Oregon accumulates drug claims to $25 before billing. If the accumulated total is less than $25 for the 60 day period prior to the billing generation, the claims will be added to the next billing cycle (every 60 days for drug claims). For all other claim types, Oregon does not accumulate billings by dollar amount or period of time and the weekly Post Payment Recovery System billing cycle is run immediately following the weekly MMIS claims cycle. All recoveries are sought within the time limits specified in 433.139(d).

THIRD PARTY LIABILITY: Payment of Health Insurance Premiums

In accord with Section 1903(a)(1) of the Act, Oregon will on a case-by-case basis pay health insurance premiums to establish or maintain coverage for Medical Assistance recipients when it is determined to be cost beneficial. Examples are:

1. When the recipient was recently separated from employment due to a layoff, medical condition or pregnancy, and retains the option to continue with the existing health coverage through the former employer.

2. When the recipient is a dependent of an employed parent or other liable party, with option to purchase such coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

See attached

U.S. Government Printing Office : 1991 - 312-149/40352

Third Party Liability: Payment of Group Health Plan Premiums

In accord with Section 1906 of the Act, implementing Section 4402 of OBRA of 1990, Oregon requires mandatory enrollment of Medicaid recipients in cost effective group health plans as a condition of Medicaid eligibility, except for an individual who is unable to enroll on his/her own behalf. Oregon pays the group health insurance premium for Medicaid individuals if cost effective. Oregon may also pay the premium for non-Medicaid individuals if cost effective and if it is necessary in order to enroll the Medicaid recipient in the group health plan. Oregon pays, subject to state payment rates, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services covered under the State Plan. Oregon pays for items and services provided to Medicaid recipients under the State Plan that are not covered in the group health plan. The group health plan will be treated as a third party resource as described in the State Plan for 42 CFR 433.138 and 433.139.

The following guidelines are used to determine cost effectiveness.

1. Determine if the group health plan is a basic/major medical policy or a health maintenance organization (HMO).

2. Determine the premium amount to be paid, converting any premiums that are not monthly, to a monthly amount.

3. Determine the number of Medicaid individuals to be covered.

4. Determine the average premium cost per Medicaid individual.

5. Determine the average monthly Medicaid cost savings for Medicaid persons who will be covered by the basic/major medical coverage or HMO coverage using the Medicaid Savings Chart.

   The Medicaid Savings Chart is updated yearly. It is based on the MMIS WMMS757R-A report which is an analysis of the costs for Medicaid recipients with third party resources versus those Medicaid recipients without third party resources. The Medicaid Savings Chart is divided into categories of assistance, as follows:

   a. Old Age Assistance
   b. Aid to Dependent Children
   c. Aid to the Blind
   d. Aid to the Disabled
   e. Foster Care

6. The Medicaid agency will pay the premium amount if the premium cost per Medicaid individual is equal to or less than the corresponding amount shown on the Medicaid Savings Chart.

The cost effectiveness of the premium payment will be reevaluated at each redetermination.

Re “Other provider(s) reimbursed on a prepaid capitation basis”, this is restricted to organizations that received grants under the Public Health Services Act in the Fiscal Year ending June 30, 1976.

Per 42 CFR 431.502: "Health maintenance organization (HMO)" means an entity determined by the Assistant Secretary for Health (Public Health Service) to meet the following requirements:

(1) It provides to its Medicaid eligible enrollees as the "basic health services" required under sec. 1301 (b) and (c) of the Public Health Service Act--

(i) Inpatient hospital services;

(ii) Outpatient services;

(iii) Laboratory and X-ray services;

(iv) Family planning services and supplies;

(v) Physician services; and

(vi) Home health services for individuals entitled to those services under the Medicaid state plan.

(2) It provides the services listed in paragraph (a) in the manner prescribed in sec. 1301(b) of the Public Health Service Act.

(3) It is organized and operated in the manner prescribed in sec. 1301(c) of the Public Health Service Act.

Per 42 CFR 431.597(b): Non-availability of FFP: The limitation under paragraph (a) of this section does not apply to HMOs or health insuring organizations meeting the criteria of sec. 1903(m)(2)(B)(i), (ii) of the Act. These organizations generally include those that received grants under the Public Health Service Act in the fiscal year ending June 30, 1976, certain rural primary health care entities, and certain entities that operated on a prepaid risk basis before 1970.

State/Territory: OREGON

Citation		
		Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are not concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b)	The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c)	When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d)	When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State/Territory: OREGON

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	P&I (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to impositions of temporary management: (c) The State's contracts with MCOs provide that payments provided for under the contract will be` denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

METHODS FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

In Oregon, the lack of a home address is not a deterrent to receiving Medicaid. Medicaid eligibility cards may be sent to anyplace the person chooses, i.e., post office box, general delivery, public shelter, etc. or the person may pick up the card at his/her local branch office.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as organized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

CHAPTER 761
AN ACT

Relating to health care; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in sections 1 to 4 of this 1991 Act:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has that meaning given in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has that meaning given in ORS 443.005.

(4) "Hospice program" has that meaning given in ORS 443.850.

(5) "Hospital" has that meaning given in ORS 442.015(13), except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has that meaning given in ORS 442.015(13) except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 2. Subject to the provisions of sections 3 and 4 of this 1991 Act, all health care organizations shall maintain written policies and procedures, applicable to all capable individuals 18 years of age or older who are receiving health care by or through the health care organization, that provide for:

(1) Delivering to those individuals the following information and materials, in written form, without recommendation:

(a) Information on the rights of the individual under Oregon law to make health care decisions including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;

(b) Information on the policies of the health care organization with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;

(c) A copy of the directive form set forth in ORS 127.610 and a copy of the power of attorney for health care form set forth in ORS 127.530, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and

(d) The name of a person who can provide additional information concerning the forms for directives and powers of attorney for health care.

(2) Documenting in a prominent place in the individual's medical record whether the individual has disputed a directive or a power of attorney for health care.

(3) Insuring compliance by the health care organization with Oregon law relating to directives and powers of attorney for health care.

(4) Educating the staff and the community on issues relating to directives and powers of attorney for health care.

SECTION 3. The written information described in section 2(1) of this 1991 Act shall be provided

(1) By hospitals, not later than five days after an individual is admitted as an inpatient, but in any event before discharge;

(2) By long term care facilities, not later than five days after an individual is admitted as a resident, but in any event before discharge;

(3) By a home health agency or a hospice program, not later than 15 days after the initial provision of care by the agency or program but in any event before ceasing to provide care; and

(4) By a health maintenance organization, not later than the time allowed under federal law.

SECTION 4. (1) The requirements of sections 1 to 4 of this 1991 Act are in addition to any requirements that may be imposed under federal law, but this 1991 Act shall be interpreted in a fashion consistent with the Patient Self-Determination Act, enacted by sections 4206 and 4751 of Public Law 101-508. Nothing in this 1991 Act requires any health care organization, or any employee or agent of a health care organization to act in a manner inconsistent with federal law or contrary to individual religious or philosophical beliefs.

(2) No health care organization shall be subject to criminal prosecution or civil liability for failure to comply with this 1991 Act.

SECTION 5. Sections 1 to 4 of this Act are added to and made a part of ORS 127.505 to 127.583

SECTION 6. If Senate Bill 494 becomes law section 5 of this Act is repealed and section 7 of this Act is enacted in lieu thereof.

SECTION 7. Sections 1 to 4 of this 1991 Act are added to and made a part of sections 1 to 21, chapter Oregon Laws 1991 (Enrolled Senate Bill 494).

SECTION 8. This Act takes effect on December 1, 1991.

SECTION 9. Sections 1 to 4 of this Act are repealed December 1, 1993.

Approved by the Governor August 5, 1991
Filed in the office of Secretary of State August 5, 1991

SECTIONS 1-4 will follow ORS 127-650 as a "Note" entitled "Obligations of Health Care Organizations". This is based on Section 8 and 9 of this act.

TN# 93-1 **Approved 2/16/93**
Supersedes TN# --- **Effective 1/1/93**

127.530 Form of power of attorney. A written power of attorney for health care shall provide no other authority than the authority to make health care decisions on behalf of the principal and shall be in the following form:

POWER OF ATTORNEY FOR HEALTH CARE

I appoint _____, whose address is _____, and whose telephone number is _____, as my attorney-in-fact for health care decisions. I appoint _____, whose address is _____, and whose telephone number is _____, as my alternative attorney-in-fact for heath are decisions. I authorize my-attorney-in-fact appointed by this document to make health care decisions for me when I am incapable of making my own health care decisions. I have read the warning below and understand the consequences of appointing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations: _____

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following.

____ Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

____ Withholding or withdrawal of artificially-administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

_____
(Signature of person making appointment/Date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is the person appointed as attorney-in-fact by this document or the principal's attending physician. Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT POWER OF ATTORNEY

I accept this appointment and agree to serve as attorney-in-fact for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

(Signature of Attorney-in-fact/Date)

(Printed name)

_____
(Signature of Alternate Attorney-in-fact/Date)

(Printed name)

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document, you should know these important facts.

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

For this document to be effective, your attorney-in-fact must accept the appointment in writing.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document does, however, have the right to withdraw from this duty at any time.

DIRECTIVE- TO PHYSICIANS 127.610

127,610 Execution and revocation of directive; form; witness qualifications and responsibility. (1) An individual of sound mind and 18 years of age or older may at any time execute or re-execute a directive directing the withholding or withdrawal of life-sustaining procedures should the declarant become a qualified patient. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this ____ day of ___ (month, year). I _____ , being of sound mind, willfully and voluntary make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I understand that full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

I hereby witness this directive and attest that:

(1) I personally know the Declarant and believe the Declarant to be of sound mind.

(2) To the best of my knowledge, at the time of the execution of this directive, I:

(a) Am not related to the Declarant by blood or marriage,

(b) Do not have any claim on the estate of the Declarant,

(c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and

(d) Am not a physician attending the Declarant, a person employed by a physician attending the Declarant or a person employed by a health facility in which the Declarant is a patient.

(1) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

Witness

Witness

(2) A directive made pursuant to subsection (1) of this section is only valid if signed by the declarant in the presence of two attesting witnesses who, at the time the directive is executed, are not;

(a) Related to the declarant by blood or marriage;

(b) Entitled to any portion of the estate of the declarant upon the decease thereof under any will or codicil of the declarant or by operation of law at the time of the execution of the directive;

(c) The attending physician or an employee of the attending physician or of a health facility in which the declarant is a patient; or

(d) Persons who at any time of the execution of the directive have a claim against any portion of the estate of the declarant upon the declarant's decease.

(3) One of the witnesses, if the declarant is a patient in a long term care facility at the time the directive is executed, shall be an individual designated by the Department of Human Resources for the purpose of determining that the declarant is not so insulated from the voluntary decision-making role that the declarant is not capable of willfully and voluntarily executing a directive.

(4) A witness who does not attest a directive in good faith shall be liable for any damages that arise from giving effect to an invalid directive.

(5) A directive made pursuant to ORS 127.605 to 127.650 and 97.990(5) to (7) may be revoked at any time by the declarant without regard to mental state or competency by any of the following methods:

(a) By being burned, torn, canceled, obliterated or otherwise destroyed by the declarant or by some person in the declarant's presence and by direction of the declarant.

(b) By written revocation of the declarant expressing intent to revoke, signed and dated by the declarant.

(c) By a verbal expression by the declarant of intent to revoke the directive.

(6) Unless revoked, a directive shall be effective from the date of execution. If the declarant has executed more than one directive, the last directive to be executed shall control. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders the declarant able to communicate with the attending physician.[Formerly97.055]

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN OREGON

DO I HAVE TO DO WHATEVER MY DOCTOR RECOMMENDS? No. You have a right to accept or refuse any proposed medical tests or treatment.

HOW WILL I KNOW HOW TO DECIDE? Your doctor will tell you what treatment or testing he or she recommends. Your doctor will then ask if you want to know more. If you-do, your doctor will tell you about the treatment or test, the available alternatives and the material risks. When you have enough information, you decide whether to have the test or treatment.

HOW CAN I PLAN AHEAD FOR A TIME WHEN I MAY BE UNABLE TO MAKE DECISIONS? Oregon has only two official forms you can sign to cover future situations where you are unable to decide. A Directive to Physician is a legal statement that you do NOT want artificial life support which would only postpone your death when you are terminally ill. A Power of Attorney for Health Care lets you designate someone you trust, your representative, to make your health care decisions for you when you can't do so yourself. It allows your representative to give most directions you could have given. Your representative cannot act for you unless you become unable to make your own decisions.

HOW DO THESE HEALTH CARE PLANNING FORMS TAKE EFFECT? If you are an adult able to make your own decisions, you can sign either or both of these forms. You do not have to fill out and sign either form if you don't want to. However, if you do, your doctor must follow it or allow you to be transferred to a doctor who will.
The forms will not affect your insurance.

HOW DO I APPOINT SOMEONE ELSE TO ACT FOR ME? By using a "Power of Attorney for Health Care" form, you may select another adult as your health care representative. You may also appoint an alternate, if you wish. The representative and any alternate must sign the form agreeing to serve. You must also decide what authority you want to give those persons. Your representative is not obligated to pay your medical bills.

HOW DO I OBTAIN AND SIGN MY WRITTEN HEALTH CARE DOCUMENTS? Health care facilities and some stationery stores have the official forms. In Oregon, the only reliable way to be sure your wishes are followed is to use the official forms. Do not change them except by filling in the blanks. Don't add anything about money or property. Each must be signed by you and two witnesses who must satisfy special requirements. Read and follow the directions. Send a copy to your doctor and to anyone you choose as a representative. Keep the original where it can be found.

JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A - OAR 411-73-030

TN No. 95-15
Supersedes
TN No. 90-16

Approval Date: 2/13/96 Effective Date: 10/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-110

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	_ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe this criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-100

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at S1919(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

__ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-080

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-090

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-070

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-110

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

No additional remedies under federal requirements.

STATE PLAN UNDER TITLE XIX OF TH3t SOCIAL SECURITY ACT

State/Territory: OREGON

DlSCLOSURE OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant
2. Information to identify each individual, including date of birth
3. Previous three places of employment (as a CNA)
4. Advanced training completed (medication aide, home health aide, psychiatric aide)
5. Date individual passed competency evaluation program or was deemed eligible
6. Information relating to findings of abuse, neglect or misappropriation of property
   a. Documentation of investigation
   b. Date of hearing, if any, and its outcome
   c. Individual's statement refuting allegation.

STATE PLAN UNDER TITLE XIX OF TH3t SOCIAL SECURITY ACT

State/Territory: OREGON

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant
2. Social Security Number
3. Information to identify each individual, including date of birth
4. Advanced-training completed (medication aide, home health aide, psychiatric aide)
5. Previous three places of employment (as a CNA)
6. Date individual passed competency evaluation program or was deemed eligible
7. Information relating to findings of abuse, neglect or misappropriation of property
   a. Documentation of investigation
   b. Date of hearing, if any, and its outcome
   c. Individual's statement refuting allegation.

Definition of Specialized Services

For Persons With Mental Retardation/Developmental Disabilities (MR/DD):

Specialized services in nursing facilities (NFs) are services paid solely by State of Oregon funds which increase access to, and participation in, community events and activities, including community-based employment and alternatives to employment (work activity centers, senior centers, etc.). If an individual's physical condition does not permit participation in community-based services, the State will provide specialized services in the NF.

For Persons With Mental Illness (MI):

Specialized services are generally not offered in NFs, but rather in psychiatric units of JCAHO-certified hospitals. Each individual's plan of care identifies specific therapies and activities to be delivered on a continuous basis (24 hour day) to treat acute episodes of serious mental illness. Interdisciplinary teams of qualified mental health professionals (each including a physician) develop, implement and supervise the individual's services. The goal of the individual plan of care is to return the individual to his or her maximal level of functioning so that they can be maintained by less intensive services.

Categorical Determinations

I. Nursing Facility Services Needed:

For persons with either Mental Retardation/Developmental Disabilities (MR/DD) or Mental Illness (MI), the State of Oregon may make an advance group determination that nursing facility (NF) services are needed for any of the following situations:

Convalescent Care:
The individuals currently in an acute care hospital recovering from an illness or surgery, the likely stay in the NF will not exceed 30 days (60 days if MR/DD), and resources necessary to meet the individual's post-NF needs are arranged or are being developed;

Terminal Illness:
The applicant's attending physician has certified, prior to NF placement, an explicit terminal prognosis with a life expectancy of less than 6 months;

Severe Physical Illness:
The individual has a severe chronic medical condition or illness that precludes participation in, or benefit from, specialized services (examples: coma, ventilator dependence, functioning at a brain stem level, chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure);

Respite Care (DD only):
The individual requires NF services for a maximum stay of 30 days per year as a respite for his or her in-home caregivers, and resources necessary to meet the individual's post-NF needs are developed; or

Emergency Situations (DD only):
The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. The length of such NF placement will not exceed 7 days.

Regardless of the original categorical determination status of each individual admitted to a NF, the State of Oregon will continue to monitor the need of every NF resident for a Level II assessment through the Annual Resident Review and other processes.

Categorical Determinations (continued)

II. Specialized Services Not Needed:

For persons with Mental Retardation/Developmental Disabilities (MR/DD), the State of Oregon may make an advance group determination that specialized services are not needed for any of the following situations:

Dementia In Combination With Mental Retardation:

The individual has a primary diagnosis of dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM), in combination with mental retardation or a related condition;

Delirium:

The individual has a primary DSM diagnosis of delirium and the State cannot make an accurate evaluation of the need for specialized services until the delirium clears;

Emergency Situations:

The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. Such placement in a NF will not exceed 7 days; or

Respite Care:

The individual will not be likely to experience a developmental or physical decline in the absence of specialized services during a respite stay (an individual's respite care schedule should remain as close as possible to the home environment's schedule).

PASARD12.04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The state has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State-wide joint trainings are offered at least annually in cooperation with the long-term care provider associations. Topics involve current regulations, policies and procedures and updates. In addition, group interviews and special exit conferences are conducted with residents and their representatives at each annual re-certification survey for the purpose of providing information about current regulations and compliance issues.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

State law and policy/procedure specify nursing facility abuse complaints must be investigated within two hours of receipt. This function is carried out by specially trained local staff in conjunction with a Registered Nurse at the State level. Investigation reports are reviewed at the State level and sanctions are levied as indicated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

All scheduling information is strictly confidential. Life safety code survey staff are not notified of the conduct of the health survey until after the entrance has occurred. Schedules are developed within a 120day window in order to avoid giving notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Quarterly trainings are held for the purpose of informing and educating survey staff in survey methods in order to reduce inconsistency. Regional office staff participate in these trainings in order to clarify regulations and policies and procedures and to interpret HCFA Central office information.

Other programs regularly incorporated into the quarterly trainings are presentations by specialty survey staff, such as dieticians and social workers; individual and group exercises to measure application of scope and frequency to citations; and exercises to measure consistency in deficiency identification by individual surveyors and survey teams.

As much as possible, survey teams are drawn from a pool for each assignment, allowing for interchange among surveyors.

Bi-weekly staff meetings include instruction on and discussion of survey consistency issues with all staff.

Additional processes to reduce inconsistency include supervisory "round table review" of survey reports together with the survey teams, and a supervisory audit procedure to review reports for consistency between offices.

Quality improvement monitoring is ongoing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A complement of staff is maintained in order to investigate complaints. Referrals are made to the State level for investigation of complaints of facility-wide substandard care or patterns of non-compliance.

Follow-up is conducted to assure correction of deficiencies identified through the re-certification survey and a mechanism exists to provide for on-site monitoring of facilities whose ability to maintain compliance is questionable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

Employee Education Regarding False Claims Recovery
Methodology of Compliance Oversight

State will oversee compliance through existing and other methodologies found to comply with requirements of Section 6032 of the Deficit Reduction Act 2005. Methods include but are not limited to contract and intergovernmental agreement approval and management; systematic quality assurance/quality improvement reviews; provider/entity enrollment procedures; provider/entity education and training; auditing. The State began to disseminate information regarding the requirements for compliance across all affected providers/entities January 9, 2007 and will follow with additional guidance through regular communication and training channels. The State will provide to all affected providers/entities basic information outlining what is necessary for compliance and material that may be used for compliance purposes. The State will continue its use of effective mechanisms available to prevent, detect and report fraud, waste and abuse in federal health care programs.

In CY 2007 affected providers/entities will be identified and provided with the information described above. Thereafter and on an annual basis, the State will obtain information on additional affected providers/entities and follow the process described above. Non MCO contracts and FFS providers/entities will be notified of the obligation to comply with state and federal regulations, contracts or agreements will be amended on the next renewal, and that the Departments oversight and compliance will begin upon receipt of notification or by September 30, 2007 which ever is first. The Department will audit provider/entities for compliance during the audit unit's regular schedule.

Managed Care contracts were amended for the term that began January 1, 2007 in order to require compliance with section 6032 referenced above. The Department reviews the MCO contractors on an annual basis for contract compliance which will also include compliance with this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OREGON

STANDARDS OF PERSONNEL ADMINISTRATION

1. See ORS Chapter 240 as amended in 1973.

2. See Personnel Rules and Merit System Laws as amended August, 1972.

3. See Rules of the Public Employee Relations Board as amended February, 1974

DEPARTMENT OF HUMAN RESOURCES	SUBJECT: NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS	NUMBER A-04	PAGE 1 OF 6
	PURPOSE: To outline procedures and policy for civil rights compliance by Dept. of Health and Human Services (DHHS) funded for DHR Divisions	REVISES ~~#01-05~~ #A-04 DATED: ~~8/80-7/1/85~~ Rev. 4-89	
		EFFECTIVE: July 1, 1985	
	AFFECTS: All DHR Divisions receiving DHHS funds.	APPROVED BY: /S/	
Policies & Objectives	STATUTORY AUTHORITY: Title VI Civil Rights Act of 1964, as amended: Section 504 of the Rehabilitation Act of 1973, Age Discrimination Act of 1975.	SECTION Administration	

1. PURPOSE

This plan outlines procedures and policies by wh1ch DHHS-(formerly HEW) funded Department of Human Resources Agencies comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended and Age Discrimination Act of 1975.

II. POLICY

Under the provisions of Title VI, Civil Rights Act of 1964 (42 USC 2000 d. et. seq.) with 45 CFR Part 80, Section 504 of the Rehabilitation Act of 1973 (29 USC 706) with 45 CFR Part 84 (Sub-parts A,b,C, and F), and the Age Discriminat10n Act of 1975 (42 U.S.C. 6101 et seg.) with 45 CFR Part 90 no individual shall, on the grounds of race, color, national origin, or persons with disabilities, or age shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under federally assisted programs and activities for which the Department of Human Resources (hereinafter called Department) has responsibility. This same policy of non-discrimination is equally applicable to all Department contractors, grantees, agents, and providers of services funded in whole or in part with Federal Funds from the Department of Health and Human Services (formerly Department of Health, Education and Welfare).

A. This policy encompasses in scope and application the civil r1ghts of employee, clients, recipients, applicants, and beneficiaries of DHHS-funded programs operated by or in behalf of the Department of Human Resources.

B. Title VI of the Civil Rights Act prohibits acts of discrimination based on race, color, and national origin.

C. Section 504 of the Rehabilitation Act prohibits discrimination based on handicap. The term "Persons with disabilities" includes such diseased or conditions as: speech, hearing, visual and orthopedic impairments, cerebral palsy, epilepsy, muscular dystrophy, HIV, multiple sclerosis, cancer, diabetes, heart disease, mental retardation, emotional illness; and specific learning disabilities such as brain dysfunction, and developmental aphasia. Alcohol and drug addicts are also considered individuals with disabilities.

D. The age discrimination act prohibits discrimination based on age in programs or activities.

The Age Discrimination Act prohibits discrimination based on age in programs of activities. The Act and the implementing regulations contain certain exceptions to the broad provision against discrimination. A program is permitted to use age distinctions in programs which have been "established under any law" such as the programs authorized by the Older Americans Act.

A facility is also permitted to take action based on age distinctions, if the action reasonably takes in to account ages as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor if all the four cond1tlons are met. These factors are referred to as the "Four Part Test".

1. Age is used as a measure or approximation of one of more other characteristics; and
2. The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
3. the other characteristic(s) can be reasonably measure or approximated by the use of age; and
4. The other characteristic(s) are impractical to measure directly on an individual basis.

III. ASSIGNMENT OF RESPONSIBILITY FOR IMPLEMENTATION OF TITLE VI AND SECTION 504, AND THE AGE DISCRIMINATION ACT.

Director

The Director, Department of Human Resources, shall designate an

TN# 89-21
Supersedes TN# 85-20

Date Approved 5/11/90
Effective Date 7/1/89

Transmittal #89-21
Attachment 7.2A, Page 101

Individual(s) responsible for overseeing department-wide Title VI and 504 and the Age Discrimination Act.

Division Administrator

Each Division Administrator within the Department of Human Resources and the Director shall designate Title VI and Equal Opportunity Coordinators to carry out compliance activities within the Divisions and Central Office of the Department of Human Resources.*

IV. TITLE VI AND SECTION 504 ORIENTATION AND/OR TRAINING

The administrator of a DHHS-funded Division shall be responsible for conveying to all Division staff their responsibilities under Title VI, Section 504 and the Age Discrimination Act. This shall be accomplished by providing, as part of a new employee's orientation and periodic retaining of permanent employee, information regarding the obligation, intent, and meaning of Title VI, Section 504 and the Age Discrimination Act.

The Administrator of a DHHS-funded Division shall ensure that members of his/her staff who have contact with program beneficiaries are aware of the ethnic, cultural, and language differences that may have important impact on the delivery of services to minority persons; and the needs of the handicapped, including any barriers to their full participation in the agency's program; and actions that result in denying or limiting services or otherwise discrimination on the basis of age. This shall be accomplished in a variety of ways, including training sessions and distribution of written information.

V. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE BY OTHER PARTICIPANTS

The Department recognizes that its obligations for compliance extend to Its service vendors, service contractors, and other providers of services, financial aid, and other covered benefits under the agency's DHHS-funded programs. The Department shall assure that such participants in its DHHS-funded programs comply with Title VI, Section 504, the Age Discrimination Act and their respective Regulations.*

VII. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE POLI CY AND PROCEDURE.

Each DHHS-funded Division shall establish a client complaint policy and procedure.*

*Details for implementation an be found in the office(s) of the Division Affirmative Action Officer and Equal Opportunity Coordinator.

VIII. RECRUITMENT AND EMPLOYMENT PRACTICES (TITLE VI AND SECTION 504)

Regard1ng Title VI, where the primary objective of the federal financial assistance to a DHR Division is to provide employment, the responsible Division shall develop policies and procedures to assure that all recruitment and employment practices for positions provided with such federal financial assistance do not discriminate on the basis of race, color, or national origin.

Even where the primary objective of the federal financial assistance is not to provide employment, each Division shall develop policies and procedures to help assure that its employment practices do not have the effect of causing discrimination in the delivery of services and benefits under its programs. -

Regarding 504, each DHR Division shall assure that no qualified "persons with disabilities" shall, on the basis of handicap, be subjected to discrimination in employment regardless of the primary objective of the federal financial assistance.

Each DHR Division shall assure that training and educational leave are provided to its employee in a non-discriminatory manner.*

IX. PLANNING, ADVISORY, AND POLICY BOARDS

Each Division shall assure that the opportunity to participate as members of planning, advisory, and policy boards, appointed or recommended by agents of the Division, which are integral parts of its program, is available to all persons in non-discriminatory manner.

X. CONTINUING COMPLIANCE

Each Division shall develop procedures for monitoring ell aspects of its operation to assure that no policy or practice is, or has the effect of, discriminating against beneficiaries or other participants on the basis of race, color, national origin, or handicap, or age. Each division shall establish a system to review all new and existing policies to determine compliance of such policies with title VI, and Section 504, and the Age Discrimination Act.*

XI. PROGRAM ACCESSIBILITY

Each Division shall assure that no qualified person with disabilities shall be denied the benefits of, be excluded from

*Details for implementation can be found in the office(s) of the Division affirmative action Officer and Equal Opportunity Coordinator.

participation in, or otherwise be subjected to discrimination under any of its programs or those of its vendors, because the facilities are inaccessible to, or unusable by persons with disabilities.

Where program accessibility has not already been achieved, because structural changes are required, each Division of the Department has set forth the steps it will take to develop its transition plan.

A system has been developed to assure that all vendors who have 15 or more employees have completed transition plans it needed.

The department shall set forth procedures for assuring that any facility or part of any facility which is constructed or altered by, on behalf of, or for their use, is made readi1y accessible to and usable by persons with disabil1ties.

XII. NEEDS A HEADING

Each Division shall assure that no person, on the bas1s of age, be denied the benefits of, be excluded from participation in, or be subject to discrimination. Any Policies which omit programs or activities on the basis of age must describe how the policy or practice takes into account age as a factor necessary to the normal operation or the achievement of a statutory objective of the program or activity. The description should include all the factors in the "Four Part Test".

XIII. CORRECTIVE REQUIREMENTS

Each Division shall take corrective action to overcome the effects of prior discrimination in instances where the Division, or its service vendors have previously discriminated against clients on the grounds of race, color, national origin, religion, sex, handicap, or age.

Even in the absence of such prior discrimination, a Division may take corrective action to overcome the effects of conditions which resulted in limiting service participation by persons of a particular race, color, national origin, or handicap, or age.

XIV. COMPLIANCE RECORDS

Each Division of the Department shall be responsible for collection and maintenance of racial/ethnic data which will show

*Details for implementation can be found in the office(s) of the Division Affirmative Action Officer and Equal Opportunity Coordinator.

the extent to which minority persons are participating in all aspects of the Division's DHHS-funded programs; i.e., day care, clinics, hospitals, sheltered workshops, etc. The Division shall require such data and information from vendors (see section on compliance by other participants).

Each Division shall make available to the Office for Civil Rights all data and information necessary to determine that Divisions compliance with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act; and its implementing Regulation, as well as the compliance status of its vendors. This information shall be reviewed by the Director, Department of Human Resources, prior to submission to the Office for Civil Rights.

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STATE OF OREGON

Transmittal #78-17
Attachment 7.3A

The Governor has delegated authority for approval of plan material which does not have a fiscal impact nor represents a significant new or revised policy, to the Director of the Department of Human Resources.

TN# 78-17
Supersedes TN# ---

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