

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER: <u>0 1 - 0 1 2</u>	2. STATE: Ohio
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX	

TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2001
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5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

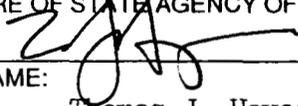
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 (a)(13)(A) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY <u>2001</u> \$ <u>1,950,778</u> b. FFY <u>2002</u> \$ <u>7,817,740</u>
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 5101: 3-3-01, 5101: 3-3-02, 5101: 3-3-20.1 5101: 3-3-45, 5101: 3-3-49.1, 5101: 3-3-49.2 5101: 3-3-49.3 5101: 3-3-49.7, 5101: 3-3-49.8 5101: 3-3-49.9, 5101: 3-3-51.4, 5101: 3-3-51.6 5101: 3-3-57, 5101: 3-3-58, and 3-3-84.5	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 4.19D 5101: 3-3-01, 5101: 3-3-02, 5101: 3-3-201 5101: 3-3-45, 5101: 3-3-491, 5101: 3-3-492 5101: 3-3-493, 5101: 3-3-494, 5101: 3-3-495 5101: 3-3-496, 5101: 3-3-497, 5101: 3-3-498 5101: 3-3-499, 5101: 3-3-514, 5101: 3-3-516 and 5101: 3-3-845
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10. SUBJECT OF AMENDMENT: This amendment contains Ohio Administrative Code rules which were promulgated in accordance with Ohio's Amended Substitute House Bill 94 and Amended Substitute House Bill 299. The department requests that the rules contained in the amendment be adopted under Attachment 4.19D of the state plan effective July 1, 2001.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      "The Governor's Office has delegated  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      review to the Director of ODJFS"

12. SIGNATURE OF STATE AGENCY OFFICIAL:  


13. TYPED NAME:  
Thomas J. Hayes

14. TITLE:  
Director

15. DATE SUBMITTED:  
September 24, 2001

16. RETURN TO:  
Becky Jackson  
Bureau of Health Plan Policy  
Office of Ohio Health Plans  
Ohio Department of Job and Family Services  
Columbus, Ohio 43215-3414

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/24/01	18. DATE APPROVED: 11/26/01
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2001	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Cheryl A. Harris	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED

SEP 24 2001

DMCH - IL/IN/OH

5101:3-3-01 Definitions.

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

- (A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the Ohio department of job and family services (ODJFS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62 and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:
- (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV;
  - (2) The provider reimbursement manual ("health care financing administration HCFA Publication 15-1,"); or
  - (3) Generally accepted accounting principles.
- (B) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit, and is calculated using the methodology described in rules 5101:3-3-42 and 5101:3-3-77 of the Administrative Code.
- (C) "Capital costs" means costs of ownership and nonextensive renovation.
- (1) "Cost of ownership" as set forth under rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code means the actual expense incurred for all of the following:
    - (a) Depreciation and interest on any items capitalized under rules 5101:3-3-511 and 5101:3-3-841 of the Administrative Code, including the following:
      - (i) Buildings;
      - (ii) Building improvements;
      - (iii) Equipment;

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- (iv) Extensive renovation;
  - (v) Transportation equipment;
  - (vi) Replacement beds;
  - (b) Amortization and interest on land improvements and leasehold improvements;
  - (c) Amortization of financing costs;
  - (d) Except as provided under paragraph (L) of this rule, lease and rent of land, building, and equipment.
- (2) "Costs of nonextensive renovation" as set forth under rules 5101:3-3-513 and 5101:3-3-843 of the Administrative Code means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.
- (D) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.
- (E) "Case-mix score" means the measure determined under rules 5101:3-3-41, 5101:3-3-42, 5101:3-3-76, and 5101:3-3-77 of the Administrative Code of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).
- (F) "Cost of construction" as set forth in rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.
- (G) "Cost per case-mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual case-mix score for

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the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the facility's cost per case-mix unit or the maximum allowable cost per case-mix unit for the fiscal year shall be used to determine the facility's rate for direct care costs, under rules 5101:3-3-44 and 5101:3-3-79 of the Administrative Code.

- (H) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter. Regardless of whether they were subsequently licensed as residential facility beds under section 5123.19 of the Revised Code. For a facility originally licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.
- (1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.
- (2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.
- (I) "Desk reviewed" means that costs as reported on a cost report submitted under rule 5101:3-3-20 of the Administrative Code and have been subjected to a desk review under rule 5101:3-3-20 of the Administrative Code and preliminarily determined to be allowable costs.

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- (J) "Direct care costs" means costs as defined under table 6 of rule 5101:3-3-~~201~~ 20.1 of the Administrative Code.
- (K) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.
- (L) "Indirect care costs" means costs as defined under table 7 of rule 5101:3-3-~~201~~ 20.1 of the Administrative Code.
- (M) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.
- (N) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."
- (O) "Maintenance and repair expenses" means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.
- (P) "Minimum data set ~~plus~~ - VERSION 2.0 " (~~MDS+~~) (MDS 2.0) is the resident assessment instrument selected by Ohio and approved by the ~~United States~~ ~~health care financing administration (HCFA)~~ CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS). The ~~MDS+~~ MDS 2.0 provides the resident assessment data which is used to classify the resident into a resource utilization group in the RUG-III case-mix classification system.

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- (Q) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."
- (R) "Other protected costs" means costs as defined under table 5 of rule 5101:3-3-20~~1~~ 20.1 of the Administrative Code.
- (S) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-25 of the Administrative Code.
- (T) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.
- (U) "Patient" includes "resident:"OR INDIVIDUAL.
- (V) Except as provided in paragraphs (V)(1) and (V)(2) of this rule, "per diem" means a NF's or ICF-MR's actual, allowable, costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that reporting period.
- (1) When calculating indirect care costs for the purpose of establishing rates under rules 5101:3-3-50 and 5101:3-3-83 of the Administrative Code, "per diem" means a facility's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been:
- (a) ~~Seventy-five per cent during calendar year 1999 and FOR~~ RATES paid effective July 1, 2000 through June 30, 2001.

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- (b) ~~Eighty-five~~ EIGHTY-TWO per cent during ~~calendar year 2000 and~~ FOR RATES paid effective July 1, 2001 and forward THROUGH JUNE 30, 2002.
  - (c) EIGHTY-FIVE PER CENT FOR RATES PAID EFFECTIVE JULY 1, 2002 AND FORWARD.
- (2) When calculating capital costs for the purpose of establishing rates under rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have during that period if its occupancy rate had been:
- (a) ~~Eighty-five~~ per cent during ~~calendar year 1999 and~~ FOR RATES paid effective July 1, 2000 through June 30, 2001.
  - (b) ~~Ninety-five~~ EIGHTY-EIGHT per cent during ~~calendar year 2000 and~~ FOR RATES paid effective July 1, 2001 and forward THROUGH JUNE 30, 2002.
  - (c) NINETY-FIVE PER CENT FOR RATES PAID EFFECTIVE JULY 1, 2002 AND FORWARD.
- (W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.
- (X) "Provider agreement" means a contract between ODJFS and a AN OPERATOR OF A NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program. THE SIGNATURE OF THE OPERATOR OR THE OPERATOR'S AUTHORIZED AGENT BINDS THE OPERATOR TO THE TERMS OF THE AGREEMENT.
- (Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.

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- (Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter and is calculated using the methodology described in rules 5101:3-3-42 and 5101:3-3-77 of the Administrative Code.
- (AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.
- (BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:
- (1) An individual who is a relative of an owner is a related party.
  - (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
  - (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.
  - (4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:
    - (a) A supplier is a separate bona fide organization;
    - (b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the

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provider and there is an open, competitive market for the types of goods or services the supplier furnishes;

- (c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;
  - (d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.
- (5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").
- (6) If a provider transfers an interest or leases an interest in a facility to another provider who is a related party, the capital cost basis shall be adjusted in accordance with rules 5101-3-3-51.5, 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative Code for a sale of a facility to or a lease to a provider that is not a related party if all of the following conditions are met:
- (a) For a NF transfer:
    - (i) The related party is a relative of owner.
    - (ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.
    - (iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:
      - (a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect

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interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

- (i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year, plus four per cent; or
  - (ii) Fifteen per cent.
- (b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.
- (c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.
- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least

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sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently under rule 5101:3-3-516 of the Administrative Code; or actual, allowable cost of ownership was determined most recently under rule 5101:3-3-516 of the Administrative Code.

- (b) For a NF lease:
- (i) The related party is a relative of owner.
  - (ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.
  - (iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:
    - (a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule , the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.
    - (b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

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- (c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.
- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently under rule 5101:3-3-515 of the Administrative Code; or actual, allowable cost of ownership was determined most recently under rule 5101:3-3-515 of the Administrative Code.
- (v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.
- (c) For an ICF-MR transfer:
  - (i) The related party is a relative of owner.
  - (ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.
  - (iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:
    - (a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the

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facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

- (i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year plus four per cent; or
  - (ii) Fifteen per cent.
- (b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.
- (c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.
- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have

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elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently under rule 5101:3-3-845 of the Administrative Code; or actual, allowable cost of ownership was determined most recently under rule 5101:3-3-845 of the Administrative Code.

- (d) For an ICF-MR lease:
- (i) The related party is a relative of owner.
  - (ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.
  - (iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:
    - (a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.
    - (b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.
    - (c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified

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appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently under rule 5101:3-3-845 of the Administrative Code; or actual, allowable cost of ownership was determined most recently under rule 5101:3-3-845 of the Administrative Code.
- (v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.
- (e) The provider shall notify ODJFS in writing and shall supply sufficient documentation demonstrating compliance with the provisions of this rule no less than ninety days before the anticipated date of completion of the transfer or lease. In the case of a transaction completed before December 28, 2000 and subject to HCFA CMS approval the provider shall supply sufficient documentation demonstrating compliance with the provisions of this rule within thirty days of the effective date of this rule. If the provider does not supply any of the required information, the provider shall not qualify for a rate adjustment. ODJFS shall issue a written decision determining whether the transfer meets the requirements of this rule within sixty days after receiving complete information as determined by ODJFS.

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- (f) Subject to approval by ~~HCFA~~ CMS of a state plan amendment authorizing such, the provisions of paragraph (BB)(6)(f) of this rule shall apply to any transfer or lease that meets the requirements specified in paragraph (BB)(6)(f) of this rule that occurred prior to December 28, 2000. Any rate adjustments which result from the provisions contained in paragraph (BB)(6)(f) of this rule shall take effect as specified in paragraph (E) of rule 5101:3-3-24 of the Administrative Code, following a determination by ODJFS that the requirements of paragraph (BB)(6)(f) of this rule are met. A provider seeking a determination from ODJFS that a transaction occurring prior to December 28, 2000, meets the requirements of this rule shall submit the necessary documentation under paragraph (BB)(6)(e) of this rule no later than thirty days after the effective date of this rule.
- (CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:
- (1) Spouse;
  - (2) Natural parent, child, or sibling;
  - (3) Adopted parent, child, or sibling;
  - (4) Stepparent, stepchild, stepbrother, or stepsister;
  - (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
  - (6) Grandparent or grandchild;
  - (7) Foster parent, foster child, foster brother, or foster sister.
- (DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining

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whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (C) of this rule.

- (1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.
  - (2) ODJFS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODJFS determines that the renovation is more prudent than construction of new beds.
- (EE) "Nonextensive renovation" means the betterment, improvement, or restoration of a NF or ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (C) of this rule.
- (FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODJFS

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under rule 5101:3-3-51 of the Administrative Code on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the rules of ODJFS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODJFS under rule 5101:3-3-51 of the Administrative Code, "construction is started" means the date in which the actual construction work begins at the facility site.

(GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR. Replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling set forth under rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code which corresponds to the period the beds were replaced.

(HH) "RUG III" is the resource utilization groups, version III system of classifying nursing facility (NF) residents into case-mix groups described in rule 5101:3-3-41 of the Administrative Code.

Effective Date: \_\_\_\_\_

Review Date: \_\_\_\_\_

Certification: \_\_\_\_\_

\_\_\_\_\_  
Date

Promulgated Under: Chapter 119.  
Statutory Authority: RC Section 5111.02  
Rule Amplifies: RC Sections 5111.01, 5111.02, 5111.20,  
Am.Sub.H.B. 94 Section 63.36  
Prior Effective Dates: 7/1/80, 8/1/84, 9/30/93 (Emer.), 1/1/94, 11/1/95,  
7/1/00, 12/28/00, 5/17/01

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TN #~~01-007~~ EFFECTIVE DATE 7/1/01

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Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

A "provider agreement" is a contract between the Ohio department of human services (ODHS) and a NF or an ICF-MR for the provision of NF services or ICF-MR services under the medicaid program. The provider's or authorized agent's signature binds the provider to the terms of the agreement.

In addition to provisions in rules ~~5101:3-3-021~~ 5101:3-3-02.1 and ~~5101:3-3-022~~ 5101:3-3-02.2 of the Administrative Code, execution and maintenance of a provider agreement between ~~ODHS~~ THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES (ODJFS) and THE OPERATOR OF a NF or ICF-MR is also contingent upon compliance with requirements set forth in this rule.

(A) DEFINITIONS.

(1) "CLOSURE" MEANS THE DISCONTINUANCE OF THE USE OF THE BUILDING OR PART OF THE BUILDING THAT HOUSES THE FACILITY AS A NF OR ICF-MR, THAT RESULTS IN THE RELOCATION OF THE FACILITY'S RESIDENTS.

(a) A FACILITY'S CLOSURE OCCURS REGARDLESS OF WHETHER THERE IS A REPLACEMENT OF THE FACILITY, WHEREBY THE OPERATOR COMPLETELY OR PARTIALLY REPLACES THE FACILITY'S PHYSICAL PLANT THROUGH THE CONSTRUCTION OF A NEW PHYSICAL PLANT OR THE TRANSFER OF THE FACILITY'S LICENSE FROM ONE PHYSICAL PLANT LOCATION TO ANOTHER.

(b) FACILITY CLOSURE ALSO OCCURS REGARDLESS OF WHETHER RESIDENTS OF THE CLOSING FACILITY ELECT TO BE RELOCATED TO THE OPERATOR'S REPLACEMENT FACILITY OR TO ANOTHER NF OR ICF-MR.

(c) A FACILITY CLOSURE ALSO OCCURS REGARDLESS OF ACTION TAKEN BY THE DEPARTMENT OF HEALTH RELATED TO THE FACILITY'S CERTIFICATION UNDER TITLE XIX OF THE SOCIAL

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SECURITY ACT, 79 STAT. 286 (1965), 42 U.S.C.A. 1396, AS AMENDED, THAT MAY RESULT IN THE TRANSFER OF PART OF THE FACILITY'S SURVEY FINDINGS TO A REPLACEMENT FACILITY, OR RELATED TO RETENTION OF A LICENSE AS A NF UNDER CHAPTER 3721. OR AS A RESIDENTIAL FACILITY UNDER CHAPTER 5123. OF THE REVISED CODE.

(d) THE LAST EFFECTIVE DATE OF THE PROVIDER AGREEMENT OF A CLOSED FACILITY WILL BE THE DATE OF THE RELOCATION OF THE LAST RESIDENT.

(2) "CONTINUING CARE" REFERS TO THE LIVING SETTING WHICH PROVIDES THE INDIVIDUAL WITH AN APARTMENT OR LODGING; MEALS; MAINTENANCE SERVICES; AND WHEN NECESSARY, NURSING HOME CARE. ALL SERVICES ARE PROVIDED ON THE PREMISES OF THE CONTINUING CARE COMMUNITY. THE INDIVIDUAL SIGNS A CONTRACT WHICH IDENTIFIES THE CONTINUUM OF SERVICES TO BE COVERED BY THE INDIVIDUAL'S INITIAL ENTRANCE FEE AND SUBSEQUENT MONTHLY CHARGES. IF A CONTINUING CARE CONTRACT PROVIDES FOR A LIVING ARRANGEMENT WHICH SPECIFICALLY STATES THAT ALL HEALTH CARE SERVICES INCLUDING NURSING HOME SERVICES ARE MET IN FULL, MEDICAID PAYMENT CANNOT BE MADE FOR THOSE SERVICES COVERED BY THE CONTRACT. IF A CONTINUING CARE CONTRACT PROVIDES FOR ONLY A PORTION OF THE RESIDENT'S HEALTH CARE SERVICES, THAT PORTION SHALL BE DEDUCTED FROM THE ACTUAL COST OF NURSING HOME CARE AND MEDICAID SHALL RECOGNIZE THE DIFFERENCE UP TO THE MEDICAID MAXIMUM PER DIEM. AN INDIVIDUAL MAY BE ELIGIBLE FOR MEDICAID AFTER A CONTINUING CARE CONTRACT WAS SIGNED UNDER THE CONDITIONS IN RULE 5101:1-39-46 OF THE ADMINISTRATIVE CODE.

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