b. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the Department prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

3. The Department will accept amended cost reports in electronic format for a period of 12 months following the end of the cost-reporting period. Cost reports may not be amended after an audit or desk review has been initiated; however, the Department maintains the right, at its discretion, to waive this requirement and allow a cost report to be amended after the desk review or audit has been initiated. When an amended cost report is received by the Department, it will notify the submitting facility if a desk review or audit covering the submitted cost report period has been initiated and that the amended cost report cannot be accepted. Amended cost reports should include a letter explaining the reason for the amendment, an amended certification statement with original signature, and the electronic format completed amended cost reports. Each amended cost report submitted should be clearly marked with "Amended" in the file name.

4. **Rate Warning:** While the Medicare regulations may allow more than one option for classifying costs, Medicaid will only recognize costs in a rate and floor component based on the case mix cross-walk shown on the case mix cross-walk tab of the Medicaid cost report template. If a facility chooses to classify cost on its Medicare cost report in a manner that excludes that cost from its direct care or care-related rate component and floor, then the cost will forever be excluded from the direct care and care-related rate and floor, unless adjusted at audit or desk review.

B. NEW FACILITIES AND CHANGES OF OWNERSHIP OF EXISTING FACILITIES

1. New facilities are those entities whose beds have not previously been certified to participate, or otherwise participated, in the Medicaid program. New facilities will be reimbursed using the statewide average case mix index to adjust the statewide direct care component of the statewide price and the statewide direct care component of the floor. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the statewide average of the facility-specific percentages determined in section C.2.c.i.(3). After the second full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with section C.2.c.i.(6)-(7) and section C.3. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the start of a calendar quarter two months or more after the facility has submitted sufficient age and square footage documentation to the Department. Following receipt of the age and square footage documentation, the new facility's capital rate will be calculated using the facility's actual age and square footage and the statewide occupancy from the most recent base year and will be effective at the start of the first calendar quarter two months or more after receipt. New facilities will receive the statewide average property tax and property insurance rate until the facility has a cost report included in a base year rate setting. New facilities will also receive a provider fee that has been determined by the Department.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity, costs, capital data, and pass-through of the prior owner. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures specified in section C.2.c.

3. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under section C.2.a. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the Secretary of the Department.

4. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with section A. These facilities will have their case-mix rates adjusted as follows:
   a. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using percentages that result in the lowest overall rate.

   b. No property tax and insurance pass-through reimbursement shall be included in the case-mix rate.

   c. The fair rental value rate calculated shall be based on 100 percent occupancy.

C. REIMBURSEMENT TO PRIVATE AND NON-STATE GOVERNMENT OWNED OR OPERATED NURSING FACILITIES

1. Definitions

Active Assessment: A resident minimum data set (MDS) assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until a subsequent MDS assessment for the same resident has been accepted by CMS, the maximum number of days (121) for the assessment has been reached, or the resident has been discharged.

Administrative and Operating Cost Component: The portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

Assessment Reference Date (ARD): The date on the Minimum Data Set (MDS) used to determine the due date and delinquency of assessments.

Base Resident-Weighted Median Costs and Prices: The resident-weighted median costs and prices calculated in accordance with section C.2., during rebase years.

Calendar Quarter: A three-month period beginning January 1, April 1, July 1, or October 1.

Capital Cost Component: The portion of the Medicaid daily rate that is:

i. attributable to depreciation;
ii. capital related interest;
iii. rent; and/or
iv. lease and amortization expenses.

Care Related Cost Component: The portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

Case Mix Index (CMI): A numerical value that describes the resident's relative resource use within the groups under the Resource Utilization Group (RUG-III) classification system, or its successor, prescribed by the Department based on the resident's MDS assessment. CMIs will be determined for each nursing facility provider on a quarterly basis using all residents.

Case-Mix Documentation Review (CMDR): A review of original legal medical record documentation and other documentation as designated by the Department in the MDS Supportive Documentation Requirements, supplied by a nursing facility provider to support certain reported values that resulted in a specific RUG classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Cost Neutralization: The process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment: An MDS assessment that is more than 121 days old, as measured by the ARD field on the MDS.

Department: The Louisiana Department of Health (LDH), or its successor, and the associated work product of its designated contractors and agents.

Direct Care Cost Component — the portion of the Medicaid daily rate that is attributable to:

i. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
ii. a proportionate allocation of allowable employee benefits; and
iii. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.