

**DEPARTMENT OF HUMAN SERVICES, MENTAL HEALTH AND
DEVELOPMENTAL DISABILITY SERVICES**

**DIVISION 43
INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED AND
OTHER DEVELOPMENTALLY DISABLED PERSONS (ICF/MR)**

309-043-0000 Purpose and Statutory Authority

(Effective 04/27/1994)

(1) Purpose. These rules establish standards by which the Mental Health and Developmental Disability Services Division approves payment for the delivery of services in Intermediate Care Facilities for Mentally Retarded and Other Developmentally Disabled Persons.

(2) Statutory Authority and Procedure. These rules are authorized by [ORS 179.040](#) and [430.041](#) to carry out the provisions of Title XIX of the Social Security Act, and **42 CFR 483, Subpart I**. Rules and standards for capital-related costs shall be consistent with **42 CFR 413, Subpart G**, as amended and the General Rules of the Office of Medical Assistance Programs, OAR 410-120-1120 et seq.

[Publications: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0005 Definitions

(Effective 04/27/1994)

As used in these rules:

(1) "Accrual Method of Accounting" means a method of accounting which recognizes revenues in the period when they are earned, regardless of

when they are collected, and expenses in the period in which they are incurred, regardless of when they are paid.

(2) "Active Treatment" means a continuous program for each individual which includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

(a) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(b) The prevention or deceleration of regression or loss of current optimal functional status.

(3) "Administrator" means the administrator of an ICF/MR.

(4) "Area Agency on Aging" (AAA) means the designated entity with which the Senior and Disabled Services Division contracts to meet the requirements of the Older Americans Act.

(5) "Assistance Workers" means those workers in the locally designated SDSD or AAA branch offices who determine financial eligibility.

(6) "Base Cost" means one of two major cost categories in the ICF/MR per diem reimbursement rate. Base cost consists of those expenses incurred in operating an ICF/MR minus the Labor Cost, which is the other major cost category.

(7) "Cash Method of Accounting" means a method of accounting which recognizes revenues only when cash is received, and expenditures only when cash is disbursed.

(8) "Change of Ownership" means a change in the entity which is responsible for the operation of an ICF/MR. Examples of events which change ownership include but are not limited to the following:

(a) Sole proprietor forms partnership; or

(b) Sole proprietor forms corporation; or

- (c) Partnership is dissolved; or
- (d) Partnership is incorporated; or
- (e) Corporation is dissolved; or
- (f) Corporation merges with another corporation; or
- (g) Corporation consolidates with one or more other corporations to form a new corporation; or
- (h) Joint venture is entered into by any two parties; or
- (i) Joint venture is dissolved.

(9) "Compensation" means the total of all benefits and remuneration, regardless of the form, paid or claimed by an owner, or an administrator or assistance administrator, or any other employee. A determination of whether compensation is reasonable may involve consideration of, but is not limited to the following:

- (a) Salaries paid or accrued;
- (b) Supplies and services provided for personal use;
- (c) Compensation paid by the facility to employees for the sole benefit of the owner;
- (d) Fees for consultation, acting as director, or any other fees paid regardless of the label;
- (e) Living expenses, including those paid for related persons.

(10) "Current Reproduction Cost" means the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(11) "DD Case Manager" means county case managers who work with MR/DD clients and are employed by community mental health programs.

(12) "Developmental Disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy or other neurological handicapping condition which requires training or support similar to that required by, individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue indefinitely;

(c) Constitutes a substantial handicap to the person's ability to function in society; and

(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "**Manual of Terminology and Classification in Mental Retardation**" by the American Association on Mental Deficiency, **1983 Revision**. Mental retardation is synonymous with mental deficiency.

(13) "Diagnosis and Evaluation Services" "D & ES" means the service of the Mental Health and Developmental Disability Services Division created by ORS 427.104 to approve application for admission to state and private training centers; process and coordinate all placement of residents from state training centers and prior approve discharge plans from private training centers; consult on diagnostic evaluation statewide; provide information to the State Training Center Review Board, as appropriate; and provide consultation to appropriate agencies and individuals regarding person evaluated in Diagnosis and Evaluation Services.

(14) "Direct Care Staff" means the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills. This staff does not include nurses, housekeepers,

maintenance or professional services included under active treatment services as defined in these rules.

(15) "Direct Care Staffing Ratio" means the staff ratios outlined in OAR 309-043-0190(2) and indicate the number of direct care staff that must be on duty in order to meet minimum staffing requirements over any given 24-hour period.

(16) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Resources.

(17) "Facility" means an establishment which is licensed by the State to provide habilitative training and care to mentally retarded persons or persons with related conditions and certified by the State as an ICF/MR under Title XIX of the Social Security Act. The term "facility" applies to all classes of facilities certified as ICFs/MR, and to distinct parts of state institutions certified as ICFs/MR.

(18) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell. Usually, the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(19) "Generally Accepted Accounting Principles" means accounting principles currently approved by the American Institute of Certified Public Accountants and other principles which have substantial authoritative support.

(20) "Goodwill" means the excess of the price paid for a business over the fair market value of all identifiable, tangible and intangible assets of that business.

(21) "Historical Cost" means the actual cost incurred by the present owner in acquiring and preparing an asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. It does not include "start-up costs" as defined in this rule. For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line

depreciation over the life of the asset to the time of the purchase or the fair market value of the asset at the time of its purchase.

(22) "ICF/MR Cost Statement" means a report of the facility's revenues, expenses, assets and liabilities.

(23) "Individual Program Plan (IPP)" means a written plan for each resident which includes both short- and long-range goals which can be measured in terms of the resident's habilitation and progression from dependent to independent functioning.

(24) "Interdisciplinary Team (IDT)" means the group representing the professions, disciplines or service areas that are relevant to identifying the individual's needs; appropriate facility staff; the individual; parents of the individual (if the individual is a minor) or the individual's legal guardian; and other agencies serving the individual convened to review and plan aspects of the resident's treatment. Each participant in the preliminary evaluation and/or Individual Program Plan process utilize the skills, competencies, insights and perspectives of his or her particular training and experience to focus on identifying the developmental needs of the resident and to devise ways to meet those needs. At least one member must be a Qualified Mental Retardation Professional. Participants share and discuss on a face-to-face basis all information and recommendations in order to develop a total unified and integrated treatment plan: Prior to the Team meeting, each participant must:

- (a) Determine the resident's current development status;
- (b) Identify developmental problems that should be ameliorated;
- (c) Develop steps that should be attained next; and
- (d) Propose ways of reaching those objectives.

(25) "Interim Per Diem Reimbursement Rate" means a temporary per diem rate used to reimburse ICFs/MR before the per diem reimbursement rate is established for the year-end settlement.

(26) "Labor Cost" means a major cost category used in computing the per diem in the reimbursement rate broken down into the following areas:

- (a) Administrative Salaries;
- (b) Other Administrative Salaries;
- (c) Nursing Services;
- (d) Direct Care Staff;
- (e) Other Salaries;
- (f) Active Treatment Services;
- (g) Payroll Taxes;
- (h) Employee Benefits.

(27) "Medicaid Specialist" means the Medicaid Specialist in the Developmental Disability Services Office of the Division.

(28) "Mental Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **Manual on Terminology and Classification in Mental Retardation** of the **American Association on Mental Deficiency, 1983 Revision**. Mental retardation is synonymous with mental deficiency:

- (a) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group;
- (b) "Developmental Period" means the period of time between birth and the 18th birthday;
- (c) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for that purpose;

(d) "Significantly Subaverage" means a score on the test of intellectual functioning that is two or more standard deviations below the mean for the test.

(29) "Model Budget Rate" means an interim rate calculated for each Small Residential Training Facility and Large Residential Training Facility according to OAR 309-043-0030(1)(a) and (b) and 309-043-0185(1)(a). The rate establishes a reasonable cost ceiling for economically and efficiently operated ICFs/MR.

(30) "Necessary" means the services or goods purchased that are required by law, prudent management, and for the normal operation of an ICF/MR or related business.

(31) "Net Per Diem Cost" means one of the alternative interim rates calculated for SRTFs and LRTFs according to OAR 309-043-0185(1)(b).

(32) "Office of Medical Assistance Programs" (OMAP) means the Office of the Oregon Department of Human Resources responsible for the coordination of medical assistance programs within the State of Oregon.

(33) "Preliminary Evaluation" means a written comprehensive, interdisciplinary professional evaluation of the client. The evaluation should be prepared prior to the client applying for Title XIX reimbursement in an ICF/MR. The evaluation must: contain background information; current, valid assessments of the individual's functional, developmental, behavioral, social, health and nutritional status; determine that the individual requires active treatment, the facility can provide for the individuals' needs, and admission is likely to benefit the individual.

(34) "Qualified Mental Retardation Professional (QMRP)" means a person who meets the qualifications of **42 CFR 483.430**. Each facility must have at least one QMRP.

(35) "Reasonable Charge or Cost" means the consideration given is equal to an amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(36) "Related Organization" means an entity which, to a significant extent, is under common ownership and/or control with, has control of or is

controlled by the contractor. An entity is deemed to "control" another entity if it has a five percent or more ownership interest in the other, or if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(37) "Residential Classification Instrument (RCI)" means an assessment tool developed by the Mental Health and Developmental Disability Services Division to help providers determine the skill level of mentally retarded/developmentally disabled persons. The RCI is required to determine the resident's classification. The RCI must be completed as part of the annual Individual Program Plan to determine the resident's classification.

(38) "Reserve Bed" means a bed that is unoccupied due to an individual's temporary absence from the facility for a home visit, community based habilitative experience, or hospitalization.

(39) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement or direction by the donor to a specific purpose.

(40) "SDSD" means the Senior and Disabled Services Division of the Department of Human Resources.

(41) "Start-Up Costs" means the one-time pre-opening costs (except Certificate of Need cost which is not included) incurred from the time preparation begins on a newly constructed or purchased building until the first ICF/MR resident is admitted. Startup costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. Architects' fees and similar costs, which are part of the historical cost of the facility, are not included.

(42) "Straight-Line Depreciation". Under the straight-line method of depreciation, the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(43) "Title XVIII" means Title XVIII of the Social Security Act.

(44) "Title XIX" means Title XIX of the Social Security Act.

(45) "Uniform Chart of Accounts" means a list of account titles identified by code numbers established by the Division for providers to use in reporting their revenues, expenses, assets and liabilities. Each Full Service Residential Training Facility (FSRTF) will use the list of account titles and cost codes provided in the Medicare (Title XVIII) cost report form number 2552.

(46) "Useful Life" means the depreciable asset's normal operating or service life to the provider, subject to the provisions of **42 CFR 413.134(b)(7)(i)**. Factors to be considered in determining useful life include normal wear and tear; obsolescence due to normal economic and technological changes; climatic and other local conditions; and the provider's policy for repairs and replacement.

(47) "Vacant Bed" means a bed that is unoccupied due to an individual's permanent discharge from the facility.

[Publications: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0010 Conditions for Payment

(Effective 04/27/1994)

In order for a facility to receive reimbursement from the Division for Title XIX ICF/ MR services, the following conditions must be met:

(1) The state has certified that the facility meets federal certification requirements.

(2) The facility is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, the Age Discrimination Act of 1975 as amended, the Americans with Disabilities Act of 1990 as amended, and any other applicable federal and state laws.

(3) A signed agreement specifying the facility class has been entered into between the Division and the facility.

(4) It has been determined by the Division that the Medicaid (Title XIX) residents are admitted, discharged and receive care in accordance with these rules as evidenced by facility records.

(5) Payment shall not be made for educational program services or vocational rehabilitation services except as allowed in **42 CFR Parts 441.13**.

(6) Payment will be made based on the Division's prior determination of the class of a facility. When a change in class occurs because of a new determination by the Division or for another reason, such as resulting from the facility's successful appeal, payment will be limited as follows:

(a) From the start of a fiscal year until the last day the former classification is effective, payment will be made as determined under these rules for the facility while in the former classification;

(b) From the date the new classification is effective until the end of the fiscal period, payment will be made as determined under these rules for the facility while in the new classification;

(c) The classification becomes effective on the date the Division Administrator or designee certifies a facility meets criteria specified in OAR 309-043-0030.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0015 Limitations

(Effective 04/27/1994)

(1) Limitation of agreements and certification:

(a) New agreements to provide services as an ICF/MR shall be entered into by the Division only with facilities which:

(A) Had agreements with the Adult and Family Services Division (AFS) as of May 24, 1978 to provide services as an ICF/MR; or

(B) Are licensed as a Nursing Home for the Mentally Retarded or General Hospital or Residential Training Facility, Center or Institution and certified as a ICF/MR.

(b) In addition to subsection (1)(a) of this rule, the Division may refuse to enter into new agreements with facilities which do not have an identified potential resident occupancy of at least 95 percent of their licensed bed capacity. The 95 percent potential occupancy may be made up of any combination of non-Title XIX and Title XIX clients. For Title XIX clients, the facility must submit the following documentation to the DD Medicaid Specialist at the Division:

(A) Client's name, address and AFS case number; and

(B) A copy of the Salem D & ES's prior authorization of payment for ICF/MR services.

(2) Limitation on payment for ICF/MR certified beds. The Division shall limit payment for care in an ICF/MR to the number of beds authorized by action of the Legislature Emergency Board.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0020 Resident Eligibility and Admission

(Effective 07/20/1990)

(1) The Division shall determine client eligibility for ICF/MR services after receipt of the following information:

(a) A preliminary interdisciplinary professional evaluation;

(b) A written evaluation by the DD Case Manager regarding the alternative resources available to the client in the home, family and community;

(c) An explicit recommendation with respect to the need for admission or, in the case of residents who make application while in a facility, the need for continued care in such facility. Where it is determined that care in a facility is required by a resident whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record and plans initiated for the active exploration of alternatives.

(2) Payment for care provided by a facility must be prior authorized by the Division. The DD Case Manager shall make a referral to the Division's Salem D & ES Unit for prior authorization of payment. The referral must include the information listed in subsection (1)(a) of this rule:

(a) Prior to requesting payment, the facility must develop an initial Individual Program Plan which includes:

(A) Diagnosis, symptom(s), complaint(s), and/or complications indicating the need for admission;

(B) A description of the functional level of the resident;

(C) Written objectives, orders (as appropriate) for services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and

(D) Plans for continuing care including provisions for review and necessary modifications of the plan and discharge.

(b) Authorization of payment will be based upon the evaluation material and recommendations and criteria outlined in federal regulations relating to Title XIX Services;

(c) Written reports of the preliminary evaluation and the written initial Individual Program Plan must be entered into the resident's record at the time of admission, or in the case of residents already in the facility, immediately upon completion;

(d) Receipt of the financial planning form from the Assistance Worker shall confirm the resident as eligible to receive Title XIX ICF/MR reimbursement services.

(3) Upon request, the facility shall grant the Division access to facility records pertaining to Medicaid residents.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0025 Plan of Care and Utilization Review

(Effective 07/20/1990)

(1) Individual Program Plan:

(a) Annually, within 365 days, the facility's Interdisciplinary Team must review the individual's comprehensive functional assessments and IPP for relevancy and update as necessary. Representatives of relevant professions, disciplines, or services; the client; and the legal guardian or parent (if the client is a minor) must participate in the review process. One member of the team must be the resident's QMRP;

(b) A facility must provide in a protected residential setting, individualized on-going evaluation, planning, continuous 24-hour supervision, coordination and integration of health and habilitative services to help each resident reach his or her maximum functioning capabilities. The Individual Program Plan shall be in writing and shall:

(A) Identify client needs as described by the comprehensive functional assessments; describe programs that meet the client's needs; state specific objectives necessary to meet the client's needs; state the planned sequence for dealing with those objectives;

(B) State each objective separately in terms of a single behavioral outcome; assign projected completion dates to each objective; express each objective in behavioral terms that provide measurable indices of performance; organize

objectives to reflect a developmental progression appropriate to the individual; and assign priorities to each objective.

(c) Annual Review. At least annually, an IDT including professions, disciplines, and services involved in carrying out the resident's Individual Program Plan shall re-evaluate the plan. Re-evaluation includes review of the resident's progress toward meeting the plan objectives, review and update of the comprehensive functional assessments, review and update of the appropriateness of the Individual Program Plan, assessment of continuing need for institutional care, and consideration of alternate methods of care.

(2) Utilization Review. All ICF/MR Utilization Review shall be done by the Division.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0030 Classes of ICF/MR Facilities and Residents

(Effective 04/27/1994)

(1) Classes of ICFs/MR. The State of Oregon has established the following three classes of ICFs/MR based upon classification of residents, size of the facility, and staffing requirements:

(a) "Small Residential Training Facility (SRTF)" means a facility having 15 or less beds and providing active treatment in a Title XIX certified facility;

(b) "Large Residential Training Facility (LRTF)" means a facility having from 16 to 199 beds that provides active treatment in an intermediate care facility under Title XIX regulations. The LRTF model budget may be applicable to a small residential training facility (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:

(A) The facility may be less than 200 beds if it meets all of the following criteria:

(i) It is certified ICF/MR and is licensed as a nursing home for the mentally retarded;

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

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

(iv) It serves any and all clients referred by the Mental Health and Developmental Disability Services Division.

(B) The Division has the option of approving only classification changes that do not increase the total number of Full Service Residential Training Facility beds in the state.

(2) Classes of ICF/MR Residents:

(a) The State of Oregon has established the following three classifications of residents in ICFs/MR which are determined by use of the Division's Resident Classification Instrument:

(A) Class "A" includes any of the following:

(i) Children under six years of age;

(ii) Severely and profoundly retarded residents;

(iii) Severely physically handicapped residents; and/or

(iv) 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. The training programs or work situations for Class "C" residents must be an integral part of the resident's active treatment program and be clearly documented in the resident's Individual Program Plan.

(b) The "A", "B", or "C" classification of each resident shall be determined by the facility administering the Resident Classification Instrument (RCI) for the ICF/MR Program within 30 days after the resident is admitted to the facility;

(c) The RCI shall be administered annually as part of the resident's annual Individual Program Plan;

(d) RCIs shall be furnished by the Division;

(e) Except for FSRTFs, the facility shall prepare a monthly report stating the current classification of each resident and shall submit with the Cost Statement a report indicating the number of resident days by classification by month.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0035 Rates

(Effective 04/27/1994)

(1) The daily rate of payment for Oregon facilities, and out-of-state facilities in areas contiguous to Oregon which accept Oregon residents on a regular basis, shall be the individual rate established by the Division for that facility based on an audit of the facility's ICF/MR Cost Statement. The Division will audit the Cost Statement, make necessary adjustments; establish the

individual daily rate(s) for that facility; and certify the established daily rate(s) to the facility.

(2) Facilities in Oregon and in areas contiguous to Oregon which provide 1,000 or fewer days of care to Oregon residents during the facility's reporting period need not file an ICF/MR Cost Statement. The Division will pay Oregon facilities 95 percent of the facility's public billing rate for up to 1,000 resident days. Payment to facilities in areas contiguous to Oregon which meet this criteria shall be made as described in section (3) of this rule.

(3) Rates for facilities described in section (2) of this rule and for out-of-state facilities in areas not contiguous to Oregon shall be made at 95 percent of the facility's public billing rate providing:

(a) The facility files with the Division its Medical Vendor Certification, certifying its Title XIX rate and its compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, the Americans with Disabilities Act of 1990 as amended, and any other applicable federal and state laws;

(b) Payment does not exceed the highest rate established by the Division for ICF/MR facilities in the State of Oregon;

(c) Oregon residents will be returned to Oregon when proper placement can be made and it is possible to do so.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0040 Cost Allocation

(Effective 07/20/1990)

(1) Full Service Residential Training Facilities shall use Medicare cost allocation methods.

(2) Except as provided in section (1), (3), (4), or (5) of this rule the allowable cost per day for each facility shall be allocated as designated below: Cost Area -- Allocation Method:

- (a) Administrative Salaries -- Resident Days;
- (b) General and Administrative -- Resident Days;
- (c) Shelter -- Square Footage;
- (d) Utilities -- Square Footage;
- (e) Laundry -- Resident Days;
- (f) Housekeeping -- Square Footage;
- (g) Dietary -- Resident Days;
- (h) Nursing Salaries -- Actual Payroll;
- (i) Nursing Supplies and Services Resident Days;
- (j) Return on Equity -- Resident Days;
- (k) Other Salaries -- Actual Payroll;
- (l) Direct Care Salaries -- Actual Payroll;
- (m) Active Treatment Services -- Actual Payroll.

(3) If the ICF/MR can demonstrate to the Division's satisfaction that a different allocation method is more reasonable and accurate, the different allocation may be used in lieu of the designated method.

(4) Where costs are non-resident related, the ICF/MR shall use an appropriate allocation method to reasonably and accurately allocate costs.

(5) If the Division finds that it is more reasonable and accurate to use a different method than specified in section (1) of this rule for a given ICF/MR, such allocation method shall be used.

(6) When a facility has designated areas for providing more than one level of care or type of care, costs shall be allocated to each of those designated areas.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0045 All-Inclusive Rate

(Effective 07/20/1990)

(1) Definition. Reimbursement by the Division constitutes payment in full for ICF/MR services. The rate established for an ICF/MR includes reimbursement for all services, supplies, and facility equipment required for care, by state and federal standards except the following:

(a) Medical care or services by outside providers paid separately through other Title XIX Medical Assistance funds, Title XVIII, Veterans Administration, etc.; and

(b) Personal incidental items authorized for payment from the resident's personal incidental allowance; and

(c) Donations as provided in OAR 309-043-0145.

(2) Inclusions. The following types of items and services are included in the all-inclusive rate. (The fact that the provider may customarily make a separate charge to private residents is irrelevant.):

(a) All care or services except as specified in OAR 309-043-0170, including restorative nursing care;

(b) Room, board and laundry (including laundry of residents' bedding and clothing whether performed by the facility or an outside provider);

(c) Items which are routinely furnished to all residents without additional costs;

(d) Items stocked by the facility in gross supply and administered individually on physician's order;

(e) Items owned or rented by the facility which are utilized by individual resident but which are reusable and expected to be available in a facility;

(f) Non-prescription, non-legend, over-the-counter pharmaceuticals not listed in Office of Medical Assistance Programs' **"Guide for Pharmaceutical Services"**;

(g) Shaves, haircuts, and shampoos as required regularly for cleanliness must be provided by the facility. These are included in the all-inclusive rate whether performed by facility staff or outside providers;

(h) All medical services, drugs and supplies except as provided in OAR 309-043-0170.

(3) Examples. The all-inclusive rate established for the facility includes but is *not* limited to:

(a) Services and Programs:

(A) Professional services as provided in OAR 309-043-0050 and 309-043-0095;

(B) Activity and therapeutic recreational programs;

(C) Behavioral management;

(D) Basic home living skill training;

(E) Social skill training;

(F) Sex education;

(G) Self help skill training;

(H) Hand feeding;

(I) Incontinency care;

- (J) Management of personal incidental funds;
- (K) Massages (by nursing staff);
- (L) Reality therapy;
- (M) Restorative aids;
- (N) Special diets;
- (O) Tray service;
- (P) Vehicles maintained by facility for transportation of residents or to conduct facility business;
- (Q) Community survival skills;
- (R) Dental consultation services beyond what is paid for by OMAP "**Title XIX Dental Care Provider Guide**";
- (S) Secure treatment;
- (T) Restorative Nursing Care;
- (U) Assistive hearing devices.

(b) Supplies:

- (A) Air mattresses;
- (B) Airway-oral;
- (C) Alternating pressure pads;
- (D) Applicators, cotton tipped;
- (E) Aquamatic K pads (water-heated pad);
- (F) Arm slings;

- (G) Bandages, including elastic or cohesive;
- (H) Basins;
- (I) Bed frame equipment (for certain immobilized bed patients);
- (J) Bedpad, regular and fracture;
- (K) Bed rails;
- (L) Bibs, including plastic;
- (M) Canes;
- (N) Catheter (any size, including indwelling);
- (O) Catheter bags, plugs and tray;
- (P) Clinitest tablets;
- (Q) Colon tubes;
- (R) Colostomy bags (including those with special rings or seals, such as a karaya seal);
- (S) Cotton and cotton balls;
- (T) Crutches;
- (U) Decubitus ulcer pads;
- (V) Deodorants, room;
- (W) Disposable underpads;
- (X) Douche bags;
- (Y) Drainage bags, sets, tubes;

(Z) Dressings (all, including surgical and dressing trays, pads, tape, sponges, swabs, etc.);

(AA) Enemas and enema supplies;

(BB) Eye pads;

(CC) Feeding tubes and units, gastric, nasal;

(DD) First aid supplies;

(EE) Flotation mattresses, pads and/or turning frames;

(FF) Folding foot cradle;

(GG) Food and food substitutes;

(HH) Food provided between meals for supplemental nourishment;

(II) Footboards;

(JJ) Gauze and gauze sponges;

(KK) Geriatric chairs;

(LL) Gloves, unsterile and sterile, examination and surgical;

(MM) Gowns, hospital;

(NN) Heat cradle;

(OO) Heat pads;

(PP) Heel protector;

(QQ) Hot pack machine;

(RR) Hot water bottles;

(SS) Ice bags;

(TT) Ileostomy bags;

(UU) Incontinency care and supplies, pants, diapers;

(VV) Infusion arm boards;

(WW) Inhalation therapy supplies: Aerosol inhalators, self-contained; Aerosol (other types); Nebulizer and replacement kit; steam vaporizer;

(XX) Intermittent positive pressure breathing apparatus;

(YY) (I.P.P.B.);

(ZZ) Invalid ring;

(AAA) Irrigation bulbs and trays;

(BBB) I.V. trays and tubing;

(CCC) Jelly, lubricating;

(DDD) Karaya rings;

(EEE) Lamps, infrared and ultraviolet;

(FFF) Laxative, proprietary;

(GGG) Linens, extra;

(HHH) Lotions and oils;

(III) Medicine dropper;

(JJJ) Nasal cannula;

(KKK) Nasal catheter;

(LLL) Nasal tube feeding;

(MMM) Needles (various sizes);

(NNN) Overhead trapeze equipment;

(OOO) Oxygen;

(PPP) Oxygen tents, masks, etc.;

(QQQ) Padding for incontinent care;

(RRR) Pumps, aspiration and suction;

(SSS) Restraints;

(TTT) Rubber rings;

(UUU) Sand bags;

(VVV) Sheepskin;

(WWW) Soap, including medicated;

(XXX) Specimen cups and bottles;

(YYY) Stomach tubes;

(ZZZ) Suction equipment and machines;

(AAAA) Syringes (all sizes) reusable and disposable;

(BBBB) Tes-tapes;

(CCCC) Thermometers;

(DDDD) Tissues, bedside and toilet;

(EEEE) Tongue depressors;

- (FFFF) Traction equipment;
- (GGGG) Tuberculin tests;
- (HHHH) Urinals, male and female;
- (IIII) Urinary tube and bottle;
- (JJJJ) Urological solutions;
- (KKKK) Walkers;
- (LLLL) Water Pitchers;
- (MMMM) Wheelchairs (see OAR 309-043-0060).

[Publications: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 430](#).041

Stats. Implemented:

309-043-0050 Payment for Medical Care and Services

(Effective 04/27/1994)

(1) Legend drugs and biologicals. Except as provided in section (5) of this rule legend drugs and biologicals provided to a resident as prescribed by a licensed physician are not included in the all-inclusive rate. Payment for such drugs is made directly to the licensed pharmacy by OMAP under the rules, regulations, and billing procedures as set forth in OMAP's "**Guide for Pharmaceutical Services.**" Resident's personal funds are not to be used for drugs and biologicals which can be furnished under the OMAP "**Guide for Pharmaceutical Services**".

(2) Influenza injections. Except as provided in section (5) of this rule injections for the prevention of influenza will not be paid by the Division on a blanket basis for all residents in the facility. The Division will give consideration to providing injections on an individual basis when justified by

the Drug Exception Procedures set forth in the OMAP "**Guide for Pharmaceutical Services**".

(3) X-ray and laboratory. Except as provided in section (5) of this rule, x-ray and laboratory procedures, provided in or out of the facility, are not included in the all-inclusive rate.

(4) Oxygen. Except as provided in section (5) of this rule, a separate supply of oxygen for a "heavy user", positive-pressure apparatus and/or respirator used solely by an individual resident, prescribed by a licensed physician, are not included in the all-inclusive rate. Payment must be prior authorized by the locally designated SDSD or AAA branch office and will be made directly to the ICF/MR at fees authorized by OMAP. A "heavy user" of oxygen is defined as a client whose oxygen need is expected to exceed an average of 1,000 liters per day in any month:

(a) Payment will be made directly to the ICF/MR when oxygen is "piped-in" and metered *if* the resident, lacking the "piped-in" oxygen, would require his own individual bedside tank. The amount of oxygen given to the resident must be accurately metered and measurable to the resident, and the oxygen must always be available to the resident. The metered amount of oxygen and dates used must be reported by the ICF/MR on the Medical Service Authorization and Invoice, as justification for payment;

(b) If a Title XIX client requires only periodic oxygen (on a PRN basis), rather than a separate supply to meet the needs of a heavy user, it will be supplied as a "house" item, either by cylinder or "piped-in". The cost of oxygen and positive-pressure apparatus and/or respirator will be included in the all-inclusive rate.

(5) Full service residential training facilities (FSRTF). FSRTF will include all medical services, oxygen, drugs and supplies, including x-ray and laboratory procedures, provided in the facility in their all-inclusive rate.

(6) Outside provider payment. When not included in the per diem rate, payment will be made directly to the physician or other provider of medical care by OMAP according to the appropriate OMAP fee schedule established for that service.

(7) Medical transportation:

(a) Costs incurred for medical transportation are included in the all-inclusive rate when provided in the facility's own vehicle, and are not when provided by a third-party carrier. Payment for medical transportation by a third-party carrier is made by OMAP to the carrier as provided in OMAP's "**Medical Transportation Guide**";

(b) The DD Case Manager is responsible for arranging all medical transportation plans utilizing third-party carriers. The carrier is determined by the resident's condition, distance to the medical facility and frequency of the trip. The least expensive mode of transportation will be utilized consistent with these conditions:

(A) Payment for medical transportation by a third-party carrier must be prior authorized by the DD Case Manager. Reasonable notice must be given by the facility to the DD Case Manager when non-emergency medical transportation is requested;

(B) Emergency medical transportation, provided by a third-party carrier when the DD Case Manager's authorization of payment cannot be immediately obtained, must be reported to the DD Case Manager as soon as feasible (but not later than the next working day) and an assessment of medical need will be made prior to payment.

(c) Cost to the facility for medical transportation provided in the vehicle of a facility employee will be included in the ICF/MR Costs Statement, Medical Transportation, as part of the all-inclusive rate. These costs must be documented by mileage figures and employee identification;

(d) Travel expense is limited to lesser of actual cost or current year IRS mileage allowance. Public transportation expense is allowable at cost.

(8) Sterilization, abortion, and hysterectomy. The OMAP "**Physician's Service Guide**" sets forth the conditions and process for which payment will be made.

[Publications: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0055 Non-Medical Transportation

(Effective 07/20/1990)

(1) Transportation for non-medical services in a facility's own vehicle to carry out a resident's training program or to carry out the facility's business is included in the all-inclusive rate.

(2) Cost to the facility for transportation related to carrying out a resident's training program or to carry out the facility's client-related business and provided in the vehicle of a facility employee will be included in the ICF/MR Cost Statement, Travel -- Non-Medical, as part of the all-inclusive rate. These costs must be documented by mileage figures and employee identification.

(3) Transportation for residents on leave of absence from the facility shall be the responsibility of the resident or the facility (see OAR 309-043-0080). This expense is *not* included in the all-inclusive rate, even though the leave may be part of the resident's Individual Program Plan.

(4) Non-medical out-of-state transportation costs are *not* included in the all-inclusive rate.

(5) Private use of the facility's vehicle is not an allowable cost.

(6) Travel expense is limited to the lesser of actual cost or current year IRS mileage allowance. Public transportation is allowable at cost.

Stat. Auth.: [ORS 430](#).041

Stats. Implemented:

309-043-0060 Personal Incidental Funds (PIF)

(Effective 04/27/1994)

(1) Each Title XIX resident is allowed to retain a specific monthly amount of income for personal needs. These personal needs include such items as clothes, tobacco, or other day-to-day incidentals. This monthly allowance is *not* to be applied toward the resident's cost of care. Generally, the source of income for personal needs is Social Security, veterans benefits, private income, Public Welfare or Supplemental Security Income (SSI):

(a) Assistance workers use the amount of a resident's income to determine:

(A) Initial eligibility for Title XIX;

(B) Amount of income and other resources which must be applied toward the resident's cost of care; and

(C) Amount of income and other resources which can be retained by the resident.

(b) Assistance workers are required to perform an annual review to determine if a resident's total funds are within the maximum allowed for Title XIX eligibility. Excess amounts shall be applied to the cost of care;

(c) The DD Case Manager must review the resident's PIF at least annually to ensure appropriate use of the funds.

(2) Allowable items. The following personal incidental items, supplies or services furnished as needed or at the request of the resident, may be paid for by the resident from the personal incidental allowance or by outside sources, such as relatives and friends:

(a) Outside barber and beautician services if requested by the resident;

(b) Personal supplies, such as toothbrushes; toothpaste or powder, mouthwashes; dental floss; denture cleaners; shaving soap; cosmetics and shaving lotions; dusting powder; cosmetics; personal deodorants; hair combs and brushes; and menstrual hygiene supplies;

(c) Dry cleaning of personal clothing provided by outside provider;

(d) Recliner chairs, standard easy chairs, radios, television sets, etc., that the resident desires for personal use;

(e) Special wheelchairs; e.g., motorized, permanent leg support, hand controlled, if needed by resident, and recommended by the attending physician. If the resident does not have sufficient funds for this equipment, Title XVIII and XIX funds should be used;

(f) Personal clothing, including robes, pajamas and nightgowns. (Bed clothing, such as hospital gowns, must be provided by the facility.);

(g) Miscellaneous items, such as tobacco products and accessories; beverages and snacks served at other than mealtime except for supplemental nourishment; television rental for individual use; stationery supplies, postage, pens and pencils; newspapers and periodicals; long-distance telephone services; non-prescription vitamins or combinations of vitamins with minerals, when ordered by the attending physician and the resident or guardian approves such use of the resident's funds.

(3) Restrictions on charges. Charges by the facility for items or services furnished Title XIX residents are not allowed as a charge against the Title XIX resident or outside sources, if separate charges are not also recorded by the facility for all non-Title XIX residents receiving these items or services directly from the facility. Charges must be for direct, identifiable services or supplies furnished individual residents:

(a) A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges may be made only after services are performed or items are delivered and charges are not to exceed charges to all classes of residents for similar services;

(b) Discretion must be exercised in making purchases for the resident. Items not pertinent to personal care and comfort should not be purchased and due care must be exercised in purchasing high cost, luxury or unusual items.

(4) Property identification. Private property shall be clearly marked with the resident's name. The facility must keep a record of private property. If items "disappear", the circumstances of disappearance must be documented in the facility's records. The facility may be responsible for losses.

(5) Records. The facility must handle each resident's account if the resident or guardian chooses not to assume this responsibility. This determination must be documented at the time of admission and at the annual IDT meeting. If the facility does handle the account, it must maintain a record of all monies belonging to the resident which have been received by or entrusted to the facility. The facility shall give an accounting of financial transactions made on behalf of the resident. Statements of account shall be provided to the resident and/or legal guardian without charge on a quarterly basis. Statements of accounts shall also be issued to the DD Case Manager and D & ES's Exit Team, as appropriate, quarterly:

(a) If PIF funds are deposited in a bank, they shall be deposited in an account separate and apart from any other bank account(s) of the facility. Any interest earned on this account shall be credited to the applicable resident's accounts;

(b) The facility shall maintain Resident Account Records for each Title XIX resident for whom the facility holds money. This record shall show in detail, with supporting verification, all monies received on behalf of the individual resident and the disposition of all funds so received. Persons shopping for residents, such as aids, volunteers, DD Case Managers, or family members, shall provide a list showing description and price of items purchased, along with receipts for these items. Outing planning sheets must be attached to the receipts, as appropriate. Records shall be available in the facility for audit and inspection by representatives of the Division. The facility shall notify the local SDS or AAA branch office and DD Case Manager when such monies exceed the asset limit established by Social Security for any individual resident so that provision can be made for application of any excess amount to the current cost of care;

(c) Availability of funds. Residents' funds on deposit with the facility shall be available to residents and/or the legal guardians upon request. It is *suggested* that a time schedule be posted in the facility stating the hours each day when the office shall be open for

withdrawal or deposit of funds. Arrangements for funds should be made in writing 24 hours in advance; funds for group outings 48 hours in advance, funds for weekend use on the preceding Friday. No funds shall be withdrawn from accounts of residents capable of making their own decisions without their permission. Withdrawals must be documented in the Resident's Account Record. Any program implemented which trains residents in possession and use of money must be documented in the Individual Program Plan and be consistent with the resident's needs and goals;

(d) Disagreements. Should the facility's Interdisciplinary Team, DD Case Manager, legal guardian and/or family disagree as to whether or not the resident is capable of handling his or her own funds, the DD Case Manager shall refer the matter to the D & ES Unit's Interdisciplinary Team for a decision. If disagreement continues, the matter should be referred to AFS for Fair Hearing;

(e) Discharge of resident. On discharge, the facility gives to the resident and/or legal guardian a final accounting of personal funds and a check for any balance on deposit with the facility;

(f) Death of resident. Within 30 days following the death of a Medicaid resident, a remittance for the balance of the resident's personal incidental funds, not used for burial, along with name and case number, shall be forwarded by the facility to the designated personal representative(s) or, if none exists, to the: Senior and Disabled Services Division, Estate Administration Unit, 500 Summer Street, N.E., P.O. Box 14021, Salem, OR 97310-1015. At death, personal property such as television sets, radios, wheelchairs, and other property of more than nominal value belong to the resident's estate;

(g) Sale of facility. Upon sale or other transfer of ownership interest of a facility, both transferor and transferee share joint responsibility in transferring resident's personal incidental fund monies and records in an orderly manner;

(h) Suspension of payments. Failure to properly record the receipt and disposition of personal incidental funds shall constitute grounds for suspension of provider payments to the facility.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0065 Payments

(Effective 04/27/1994)

(1) Bills shall be submitted to the Division as soon as possible after the date service is rendered. The Division will not make payment for services which were provided more than 24 months prior to presentation of the claim to the Division.

(2) The local SDSD or AAA branch office shall notify the facility of any known funds, and their location, available to a resident for personal incidental needs. Such funds will be offset by crediting the established Title XIX amount paid to that facility as specified in OAR 309-043-0060(1)(a), (b) and (c). The total available income shall be deducted as a credit toward the amount billed. Funds which become known to the facility shall be reported to the local SDSD or AAA branch office. The facility is responsible for collecting such funds.

(3) The total available income, after personal incidental needs are met, shall be deducted as a credit toward the amount billed. Funds which become known to the facility shall be reported to the local SDSD or AAA branch office. The facility is responsible for collecting such funds.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0070 Days Chargeable

(Effective 07/20/1990)

(1) The Division will pay for the day of admission, but not for the day of discharge, transfer, or death.

(2) Vacancies. The Division may make payment for a vacant bed up to 30 days only in Small and Large Residential Training Facilities. Any vacancy longer than 30 days must be prior authorized by the Developmental Disability Services Medicaid Specialist. The facility must notify the Medicaid

Specialist in writing at least one week prior to the expiration of the 30-day vacancy to request approval to continue the vacancy. The request must be submitted in accordance with criteria established by the Division. The Developmental Disability Services Medicaid Specialist will evaluate and approve requests on a case-by-case basis.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0075 Services Billed

(Effective 04/27/1994)

(1) 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.

(2) In determining the customary charges to private client for use in billings or calculating interim and settlement rates, the following criteria shall be applied:

(a) The private client billing rate must be for items and services comparable to the items and services included in the all-inclusive rate for ICF/MR care; and

(b) When private client rates are based on the number of beds in the room, the Division considers the lowest room charge as the usual and customary charge for services; or

(c) When ancillary charges are made to private clients in addition to a basic charge, the Division considers the usual and customary charge to be the lowest basic room charge plus the average ancillary charge for those items included in the ICF/MR rate. The average ancillary charge is determined by dividing the ancillary revenue by the number of private client days; or

(d) When a point system is used to determine private client rates, the Division considers the usual and customary charge to be the average charge for services in subsection (a) of this section. The average charge shall be calculated by dividing private client revenue, less

one-time charges (for items such as medical evaluations, dental screenings, and admission fees), by private client days; or

(e) When charges are based on the classification of the client (i.e., Medicare, Medicaid, Private), the Division considers the usual and customary charge to be the rate for private clients exclusive of ancillary charges.

(3) The facility's private client billing rates are to be entered on the ICF/MR Cost Statement.

(4) Bills shall be processed on OMAP-approved billing forms or electronic media.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0080 Reserved Bed Payments

(Effective 04/27/1994)

(1) 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 absence due to hospitalization or convalescence in a nursing facility. In Small and Large Residential Training Facilities the DD Case Manager must be notified in writing of any resident's absence from the facility. In Full Service Residential Training Facilities, the facility's medical records office and billings unit must be notified in writing of any resident's absence from the facility.

(2) Prior to the resident's departure for leave to exceed 14 consecutive days, the Small or Large Residential Training Facility must submit a written request to the DD Case Manager for authorization of reserved bed payments. The medical records office in Full Service Residential Training Facilities must submit a written request to the Developmental Disability Services Medicaid Specialist for authorization of reserve 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:

(a) Absences of 14 days or less do not require prior authorization, but the Division reserves the right to decline payment, if appropriate;

(b) For Small and Large Residential Training Facilities the DD Case Manager must notify the Developmental Disability Services Medicaid Specialist, of any temporary absence in excess of 30 consecutive days. For Full Service Training Facilities, the medical records office must notify the Developmental Disability Services Medicaid Specialist of any temporary absence in excess of 30 consecutive days. Prior authorization of such absences requires the signature of both the DD Case Manager and the Medicaid Specialist for residents in Small and Large Residential Training Facilities. For Full Service Residential Training Facilities, prior authorization of such absence requires the signature of the Developmental Disability Services Medicaid Specialist.

(3) The DD Case Manager shall notify the local SDSD or AAA branch office in writing of any reserved bed denials for residents in Small and Large Residential Training Facilities. The Developmental Disability Services Medicaid Specialist shall notify the local SDSD or AAA branch office in writing of any reserve bed denials for residents in Full Service Residential Training Facilities. 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.

(4) Reserved bed payments shall be limited to 14 days in any 30-day period, except for those absences prior authorized by the DD Case Manager or the Developmental Disability Services Medicaid Specialist.

(5) 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 309-043-0065.

(6) 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.

(7) 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 OMAP-approved 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.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0085 Transfer or Discharge of Residents

(Effective 07/20/1990)

(1) Transfer of residents:

(a) A resident shall not be transferred to another facility without review and discharge planning by the Interdisciplinary Professional Team of the transferring facility. The DD Case Manager must participate in the discharge planning and the plan must be submitted to the MHDDSD D & ES Unit in Salem for final approval. The discharge plan shall be submitted by the DD Case Manager;

(b) The DD Case Manager shall discuss any planned move from one facility to another with the resident, guardian, and relatives of the resident, as appropriate;

(c) In FSRTF's, the Unit Social Worker shall refer residents for discharge directly to D & ES for discharge planning;

(d) Failure on the part of the facility administration to comply with this rule shall constitute a basis for withholding payment.

(2) Discharge of residents:

(a) Requests for discharge of residents may be initiated to the DD Case Manager by the facility's Interdisciplinary Team, the resident, the resident's family, and/or the resident's legal guardian;

(b) The DD Case Manager will coordinate the plans for discharge. A discharge plan must include provision for appropriate services in the resident's new environment, protective supervision, if required, other follow-up services, and appropriate written documentation from the client's record. The DD Case Manager will discuss the discharge plans with the resident and/or legal guardian;

(c) When a resident is permanently discharged, the facility must prepare and place in the resident's record a summary of findings, progress and plans;

(d) The Mental Health and Developmental Disability Services Division's D & ES Unit in Salem shall have final approval for all discharge plans;

(e) Failure on the part of the facility administration to comply with this rule shall constitute a basis for withholding payment.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0090 Accounting and Record Keeping

(Effective 07/20/1990)

(1) ICF/MR Cost Statements shall be prepared in conformance with generally accepted accounting principles and the provisions of this rule. Where a conflict exists, the provisions of these rules shall prevail.

(2) Full Service Residential Training Facilities shall apply Medicare Principles of Reimbursement when filing ICF/MR Cost Statements. All other facilities shall file ICF/MR Cost Statements using the accrual method of accounting.

(3) The facility shall maintain, for a period of not less than three years following the date of submission of the ICF/MR Cost Statement to the Division, financial and statistical records of the period covered by such cost statement which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved audit questions at the end of this three-year period, the records must be maintained until the questions are

resolved. The records shall be maintained in a condition that enable them to be audited for compliance with generally accepted accounting principles and provisions of these rules.

(4) Expenses reported as allowable costs must be adequately documented in the financial records of the facility or they shall be disallowed.

(5) The Division shall maintain each required ICF/MR Cost Statement submitted by a provider for three years following the date of submission of the report. In the event there are unresolved audit questions at the end of this three-year period, the cost statement shall be maintained until such questions are resolved.

(6) The records of the facility shall be available for review without notice by authorized personnel of the Department and of the U.S. Department of Health and Human Services during normal business hours at a location in the State of Oregon specified by the facility.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0095 Professional Services

(Effective 07/20/1990)

(1) No professional consultation, treatment, evaluation or medical service costs other than the following will be included in the facility's all-inclusive rate: Dentist*; dietitian; interpreter for the deaf; occupational therapist; pharmacist*; physical therapist; psychologist; qualified mental retardation professional; registered nurse; social worker; speech pathologist/therapist; audiologist; and recreation therapist.

NOTE: *Means for consultation services beyond costs paid under the appropriate OMAP provider guide.

(2) Full Service Residential Training Facilities shall provide all of the professional services cited in section (1) of this rule with their own staff or by contract and their costs are included in the all-inclusive rate.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0100 Non-Paid Workers

(Effective 12/11/1981)

(1) The Division shall consider the value of services performed by non-paid workers in positions that are normally occupied by paid personnel of the facility to be an allowable cost when all of the following criteria are met:

(a) Services are related directly to resident care or for administrative purposes essential to providing that care; and

(b) Non-paid workers spend a minimum of 20 hours per week on the job; and

(c) The non-paid workers do not receive any direct remuneration (salaries, wages or gifts) from either the facility or from the organization of non-paid workers; and

(d) The Division does not reimburse any workers for services traditionally rendered on a purely volunteer basis without expectation of any form of remuneration by the non-paid workers' organization (American National Red Cross, hospital guilds, auxiliaries, and similar organizations); and

(e) Non-paid workers are members of an organization of non-paid workers that has arrangements with the facility for the performance of services by non-paid workers; and

(f) The non-paid worker organization has a tax exempt status from the United States Internal Revenue Service; and

(g) A legally enforceable agreement exists between the facility and the organization of non-paid workers. The agreement establishes the facility's obligation to make payments to the organization for services rendered by its members; and

(h) The facility maintains records which show the value of non-paid services as rates of pay in a manner equivalent to that used for paid

employees. In addition, the records contain a copy of the contract between the organization of non-paid workers and the facility; and

(i) The qualifications of non-paid workers are comparable to the qualifications of paid employees performing identical services under similar circumstances; and

(j) The calculation of the value of services of non-paid workers only includes payments to the non-paid workers' organization for that worker's services, the cost of any room and board, perquisites (such as uniforms and laundry), and fringe benefits provided free of charge by the facility. The total value of services may not exceed amounts allowed for paid employees performing similar services; nor may it exceed the amount provided by the terms of the contract between the facility and the organization of non-paid workers.

(2) The agreement between the facility and the organization of non-paid workers must include the following:

(a) Amount applicable to the value of services rendered by non-paid workers;

(b) Types of services;

(c) Title of each full-time position;

(d) Number of hours;

(e) Rates of pay per working classification (including salary, fringe benefits, perquisites, and maintenance); and

(f) Period of time during which services are rendered.

(3) Payments for services described in section (1) of this rule shall not be allowed if not paid by the facility, or if paid by the facility later than 75 days after the end of the facility's cost reporting period in which the services were rendered.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0105 Owner Compensation

(Effective 12/11/1981)

(1) Compensation of owners for services normally result through the ICF/MR facility earned profit. The only other owner compensation recognized as an allowable cost is when the owner is employed in the ICF/MR and meets the provision of this rule.

(2) Reasonable compensation for services performed by owners or immediate relatives is an allowable cost, provided the services are actually performed in the ICF/MR, documented and are necessary. Persons considered to be immediate relatives are husband, wife, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, mother-in-law, half-brother, half-sister, father-in-law, grandparent, grandchild, uncle, aunt, nephew, niece and cousin:

(a) Reasonableness requires that the compensation allowance:

(A) Does not exceed an amount ordinarily paid for comparable services performed by either other facility employees or non-owners at other facilities; and

(B) Includes only the benefits and remuneration, regardless of the form, provided to all employees in like manner; and

(C) Is consistent with "reasonableness" as defined in OAR 309-043-0005.

(b) Services actually performed and necessary requires that:

(A) The services be only those rendered in connection with client care whether direct or indirect. This excludes services characterized as protecting the owner's investment; and

(B) The services are limited to those positions described in the salaried accounts included in the schedule of labor costs; and

(C) Had the owner not rendered the services the facility would have had to employ another person to perform them; and

(D) The services must be pertinent to the operation and sound conduct of the facility as well as comparable to services purchased by the other ICFs/ MR in similar situations.

(c) Documentation requires that:

(A) A position description exists to support the duties and responsibilities being compensated; and

(B) Employee records be maintained to support owner's work week and rate of pay, whether hourly or salary; and

(C) Compensation be paid. Accrued compensation of an owner, if not paid within 75 days after the end of the ICF/MR cost statement reporting period, shall not be included as an allowable expense except as identified in section (4) of this rule.

(3) An owner will not be compensated for services in excess of 40 hours in one week. Particular scrutiny shall be required where an owner may provide services in more than one area for more than one facility or is engaged in other occupations or business activities. Allowable compensation will be adjusted to reflect an appropriate allocation of time spent in each area.

(4) Where an owner functions as an administrator or assistant administrator, the sections of rules governing compensation of these positions apply.

(5) The allowance of compensation for services of sole proprietors and partners is the amount determined to be the reasonable value of the services rendered regardless of whether there is any actual distribution of the profits of the business. However, imputed compensation is allowable only when there is a corresponding entry to account 1970-Drawing Account-Proprietor or Partner.

(6) The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the

manner in which this authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, might perform most day-to-day managerial and supervisory functions in an institution. In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar institutions. The owner is compensated for managing and protecting his or her investment through the ICF/MR profit; in this example the administrator's salary would not be an allowable cost.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0110 Auditing

(Effective 04/27/1994)

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

(2) The desk review shall verify, to the extent possible:

(a) That the facility has properly included its allowable costs on the ICF/MR Cost Statement on the basis of generally accepted accounting principles and in compliance with these rules; and

(b) That the facility has properly applied the cost finding method to its allowable costs as specified by the Division in accordance with OAR 309-043-0040;

(c) Whether further auditing of the facility's financial and statistical records is needed.

(3) All ICF/MR Cost Statements filed with the Division shall be subject to a field audit, normally to be completed within one year from the date of filing.

(4) The field audit shall, at a minimum, be sufficiently comprehensive to verify that in all material respects:

- (a) Generally accepted accounting principles and the provisions of these rules have been adhered to; and
- (b) Reported data is in agreement with supporting records; and
- (c) The ICF/MR Cost Statement is reconcilable to the appropriate IRS report and payroll tax reports;
- (d) The model budget rate described in OAR 309-043-0005 supports 100 percent of an efficiently and economically operated facility.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0115 Capital Assets

(Effective 04/27/1994)

Capital Assets included on the ICF/MR Cost Statement are as follows:

(1) Tangible assets of the following types in which a provider has an economic interest are subject to depreciation:

(a) "Buildings" mean the basic structure or shell and additions thereto;

(b) "Building fixed equipment" means attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning system. The general characteristics of this equipment are:

(A) Affixed to the building and not subject to transfer;

(B) A fairly long life, but shorter than the life of the building to which affixed.

(c) "Moveable equipment" means such items as beds, wheelchairs, desks, vehicles, and other depreciable items;

(d) "Land improvements" means such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., the replacement of which is the responsibility of the facility;

(e) "Leasehold improvements" means the betterments and additions made by the lessee to the leased property which become the property of the lessor after the expiration of the lease.

(2) Land is not depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, and the cost of curbs and sidewalks, replacement of which is not the responsibility of the facility.

(3) Amortization of intangible assets shall not be included in calculating the reimbursement rate except for those specifically mentioned in the following rules:

(a) Start-up costs as provided in OAR 309-043-0135; and

(b) Organization costs as provided in OAR 309-043-0140.

(4) Assets shall be capitalized and depreciated if they have historical costs in excess of the level required by the lower of:

(a) The State of Oregon accounting policy; or

(b) The Medicare capitalization policy.

(5) Repair costs in excess of \$1,000 on equipment or buildings must be capitalized to the extent that they extend the useful life beyond the originally estimated useful life, expand the capabilities, or result in a betterment of the asset.

(6) Certificate of Need shall be capitalized and amortized as part of the building cost.

(7) The facility shall maintain receipts and depreciation schedules of capital assets to document amounts reported on the ICF/MR Cost Statement.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0120 Depreciation

(Effective 04/27/1994)

(1) Basis:

(a) Purchase of new facility. The basis for depreciation of a new facility shall be the historical cost of building the facility, including preparation for use, or the purchase price from an unrelated organization not to exceed the fair market value, including preparation for use, less salvage value;

(b) Purchase of ongoing facility. The basis for depreciation of an ongoing facility acquired from an unrelated organization is limited to the lower of the following:

(A) The allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984;

(B) The acquisition cost of such asset to the new owner; or

(C) The fair market value of the asset on the date of acquisition.

(c) To properly provide for cost or valuation of fixed assets, appraisal by an expert will be required if the facility has no historical cost records, has incomplete records of depreciable fixed assets, or purchases a facility without designation of purchase price for the class of assets acquired. The appraisal shall be subject to the approval by the Division. In any case, the Division may require such appraisal to establish the fair market value of the facility's assets;

(d) If the purchase is from a related organization, the cost basis is the lower of the cost basis of the related organization, or the cost basis

as determined by subsections (1)(b) and (c) of this rule, less depreciation as determined by the provisions of this rule;

(e) The basis for depreciation of assets other than as described in subsections (1)(a) and (b) of this rule shall be the historical cost to the facility from an unrelated organization plus set-up costs, less salvage value. The basis shall not exceed the fair market value. In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid. In cases where the asset is purchased from a related organization, the basis shall not exceed the asset's book value as determined under the provisions of this rule;

(f) Depreciation expenses associated with donated assets shall be included in the calculation of the reimbursement rate as provided in OAR 309-043-0145;

(g) The asset value and annual depreciation shall be reduced by the value of assets determined to be both not necessary and not related to resident care;

(h) Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation;

(i) Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets. Funded depreciation account funds must be placed in readily marketable investments of the type that assures the availability and conservation of the funds. Additions to the funded depreciation account must remain in the account for at least six months to be considered valid funding transactions.

(2) Methods. The straight-line method of depreciation shall be the only method used in depreciating assets, effective on and after November 1, 1978:

(a) If other depreciation methods used were in use prior to November 1, 1978, the cost basis on that date shall be the undepreciated

balance. The method and procedure for computing depreciation must otherwise be applied on a basis consistent from year to year;

(b) The additional first year allowance is not allowable.

(3) Asset lives:

(a) Small and Large Residential Training Facilities shall use Internal Revenue Service guidelines for setting asset lives when computing allowable depreciation for Title XIX reimbursement purposes for assets acquired before January 1981. The lives of assets not covered by Internal Revenue Service guidelines which cost more than \$200 individually and \$400 aggregate are subject to approval by the Division. For assets acquired on or after January 1, 1981, facilities shall use the useful life guidelines published by HCFA or other guidelines as established at **42 CFR 413.134(b)(7)(i)**.

(b) For Small and Large Training Facilities improvements to leased property which are the responsibility of the facility under the terms of the lease shall be depreciated over the useful life of the improvement or over the remaining length of the lease, whichever is shorter. The improvement shall be depreciated only over the useful life of the improvement in the case of lease to a related party;

(c) Full Service Residential Training Facilities shall use Medicare principles to determine asset lives for depreciation.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0125 Retirement or Disposal of Depreciable Assets

(Effective 07/20/1990)

(1) Retirement of assets:

(a) Depreciation shall no longer be taken on depreciable assets which are disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. No further depreciation shall be taken on permanently abandoned assets;

(b) When an asset has been retired from active use but is being held for standby or emergency service, and there is a likelihood that it can be effectively used in the future, depreciation may be taken.

(2) Gains on disposal of depreciable assets:

(a) A gain on the sale or trade of an asset is the excess of all proceeds received for the asset over its remaining undepreciated base. Any gain on the sale or trade of a depreciable asset, either during the period of participation in the program or within 12 months following termination, shall be included in computing the settlement rate for the period in which the asset was disposed as follows:

(A) For assets with expected useful lives of less than 100 months, that portion of the total gain relative to the reimbursement for Title XIX residents shall be subject to recovery as set forth in paragraphs (2)(a)(C) and (D) of this rule shall; and

(B) For assets with expected useful lives of 100 months or more, that portion of the total gain relative to the reimbursement for Title XIX residents, subject to recovery as explained in paragraphs (2)(a)(C) and (D) of this rule shall be limited to the total gain reduced by one percent for each month of ownership; and

(C) Any gain on the sale or trade of an asset will be spread over the actual life of the asset on the same basis as depreciation was allowed to the date of retirement. Depreciation schedules for fiscal years during which the facility participated in the ICF/MR program shall be adjusted by reducing the depreciation expense taken for that asset. The difference between reimbursement actually paid for depreciation in any period beginning November 1, 1978, and the reimbursement for depreciation which would have been paid with the depreciation schedules adjusted to reflect the gain shall be recovered by the Division as explained in paragraph (2)(a)(D) of this rule; and

(D) In the period an asset is sold or traded, any gain shall be recovered by reducing the settlement rate by the amount of the

gain as calculated in paragraph (2)(a)(C) of this rule, divided by the total Title XIX resident days; and

(E) A loss on the sale or trade of an asset is the excess of the remaining undepreciated base over all proceeds received for that asset. A loss shall not be included in the calculation of the reimbursement rate; and

(F) All proceeds from the sale of donated assets shall be treated as a donation as provided in OAR 309-043-0145.

(b) Losses from the disposal of depreciable assets are not allowable cost for ICF/MR reimbursement except in facilities following Medicare principles of reimbursement. In these facilities, Medicare principles regarding disposable assets will apply.

(3) Payments to providers shall not be increased, solely as a result of a change of ownership, in excess of the increase which would result from applying Section 1861(v)(1)(O) of the Social Security Act as applied to owners of record on or after July 18, 1984.

Stat. Auth.: [ORS 430.041](#)

Stats. Implemented:

309-043-0130 Equity

(Effective 09/25/1985)

(1) An allowance of ten percent return on average equity capital invested and used in the provision of resident care is included as an allowable cost in determining reimbursement, subject to the maximum payment level. This allowance shall be payable only to profit making proprietary entities and shall not be allowable to non-profit or governmental entities.

(2) The average equity capital of the provider will be determined by adding together the beginning and ending equity capital for the reporting period and dividing by two. The product of the average equity capital and the rate of return on equity shall be included on the ICF/MR Cost Statement in calculating the cost per resident day. If the net average owner's equity is zero or negative, there will be no return:

- (a) Generally accepted accounting principles are to be used for computing owner's equity unless otherwise specified in this rule;
- (b) Assets and liabilities not related to providing resident care and home office assets and liabilities are not includable in the facility's equity capital;
- (c) Loans from owners or related entities are considered invested equity capital of the facility for which the allowance of a return on equity capital in section (1) of this rule will apply;
- (d) Owner's equity in assets leased from related entities is includable in the equity capital of a proprietary facility;
- (e) Goodwill is not includable as part of owner's equity;
- (f) Amounts deposited in a funded depreciation account and the earnings on these deposits are not included in equity capital;
- (g) Land, buildings, and other assets acquired in anticipation of expansion are not includable in equity capital. Construction-in-process and liabilities related to such construction are not includable in equity capital;
- (h) Prepaid premiums on life insurance carried by a facility on officers and key employees, which designate the facility as the beneficiary, are not includable in equity capital;
- (i) The costs of noncompetitive agreements are not includable in equity capital;
- (j) The amount deposited in, and the earnings of, a self-insurance reserve fund are not includable in equity capital;
- (k) The unrecovered loss of an asset which is totally or partially destroyed by a casualty is not includable in equity capital;
- (l) Working capital, defined as the difference between current assets and current liabilities, shall be adjusted by any amount determined to

be excessive for the necessary and proper operation of resident care activities. The excessive amount will not be included in equity capital;

(m) The cash surrender value of insurance is not includable in equity capital;

(n) Imputed salaries for proprietors will be offset in computing the equity capital;

(o) Donations shall not be included as part of owner's equity;

(p) Any portion of an acquisition cost incurred on or after July 18, 1984, that exceeds the depreciable basis, as defined by OAR 309-043-0120, is not includable in the owner's equity calculation.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0135 Start-up Costs

(Effective 12/11/1981)

(1) Necessary and ordinary start-up costs will be allowable if they are amortized over not less than 60 consecutive months beginning with the month in which the first ICF/MR resident is admitted for care.

(2) Start-up costs will be limited to those appropriate costs incurred within six months prior to the date of admission of the first ICF/MR resident to the facility.

(3) The Division may grant an extension to the six-month limitation if the opening of the facility is delayed by the Department of Human Resources or one of its Divisions.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0140 Organizational Costs

(Effective 07/20/1990)

(1) Necessary and ordinary costs which are directly incident to the creation of a corporation or other form of business of the facility, shall be allowable if they are amortized over not less than 60 consecutive months beginning with the month in which the first ICF/MR resident is admitted for care.

(2) Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation. Cost relating to the issuance and sale of shares of capital stock or other securities are not allowable.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0145 Offset Income and Donations

(Effective 12/11/1981)

(1) Except as prescribed in subsection (1)(b) and section (2) of this rule all income may be used to offset expenses:

(a) If a facility provides a service which results in a revenue producing activity which is non-allowable cost (i.e., activity center, TMR Class, sheltered workshop, skilled nursing), the revenue shall be offset as follows:

(A) If the revenue is less than two percent of the total facility expense (sum of cost areas), it shall be offset against the appropriate expense;

(B) If the revenue is two percent or more of the total facility expenses (sum of cost areas), costs must be allocated to this area as described in OAR 309-043-0040.

(b) Income for routine services or supplies included in the all-inclusive rate will not be offset against expenses.

(2) Donations made to an ICF/MR will be included in the calculation of the reimbursement rate as follows:

- (a) Grants, gifts, or endowment income designated by a donor for paying a specific operating cost will be offset against that cost;
- (b) Unrestricted grants, gifts, and income from endowments will not be offset from operating costs in computing reimbursable costs;
- (c) The basis of depreciation for a donated asset:
 - (A) If acquired from a related organization, shall be the lesser of:
 - (i) Fair market value at the date of acquisition; or
 - (ii) The basis the related party had or would have had if they participated in the program; or
 - (B) If acquired from a non-related organization, shall be the fair market value at the date of acquisition.

Stat. Auth.: [ORS 430](#)
Stats. Implemented:

309-043-0150 Related Party Transactions, Chain Operations, Home Office Cost

(Effective 07/20/1990)

(1) Related party transactions:

(a) Except as provided in subsection (1)(b) of this rule, costs applicable to services, facilities and supplies furnished to a facility by organizations related to the facility by common ownership or control are allowable at the lower of cost excluding profits and mark-ups to the related party or charge to the facility:

(A) Compensation paid to employees is also reviewable under the test of reasonable compensation for services performed by owners as described in OAR 309-043-0105;

(B) Related party costs are allowable to the extent that they relate to resident care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer;

(C) Related party costs that are not otherwise allowable costs when incurred directly by the facility shall not be allowable as related party costs;

(D) Documentation of costs to related parties shall be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be disallowed.

(b) An exception to the general rule on related organizations may be granted if the facility demonstrates by clear and convincing evidence to the satisfaction of the Division:

(A) That the supplying organization is a bona fide separate organization; and

(B) That a substantial part of the supplying organization's business activity, of the type carried on with the facility, is transacted with other organizations not related to the facility and the supplier by common ownership or control, and that there is an open, competitive market.

(c) Rental expense paid to related organizations for facilities or equipment shall be allowable to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on mortgage) or leasing the assets, computed in accordance with the provisions of this rule.

(2) Chain operations:

(a) A chain operation consists of a group of two or more health care facilities including one or more ICFs/MR which are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains but also chains operated by

various non-profit entities including counties, hospital districts, and religious and other charitable organizations;

(b) Home offices of chain operations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a facility itself, it may furnish to the individual facility central administration and/or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services to the facility is includable in the facility's allowable costs under the program;

(c) Home office costs that are not otherwise allowable costs when incurred directly by the facility shall not be allowable as home office costs to be allocated to facilities. Where the home office is a holding company and provides no services related to resident care, neither costs nor equity capital of the home office may be recognized as allowable cost to the facilities in the chain;

(d) If an owner receives compensation from the home office for services to the facility, that compensation shall be allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined in OAR 309-043-0105.

(3) Allocation of home office cost:

(a) Home office costs attributable to a specific facility shall be reported in the Home Office expense column of the ICF/MR Cost Statement except for facilities following Medicare principles of reimbursement. In these facilities, home office costs will be reported on the Medicare Home Office Cost Report. The costs reported are to be the net allowable costs defined in section (2) of this rule and based on the account definitions in OAR 309-043-0200;

(b) The home office will attach a worksheet to the cost statement for the facility showing the detailed gross home office costs, adjustments, and net home office allowable costs and the allocated costs to each facility and non-resident (client) related activity;

(c) The home office will include, on the attached worksheet, the allocation method(s) used to allocate costs to the facility or facilities. Generally, costs will be based on beds, resident days or other bases, whichever most equitably allocates such costs. Revenue is not generally appropriate for distributing these costs;

(d) Home office costs directly attributable to a specific facility, such as administrator's salary, shall be reported as part of the facility's costs in the facility's gross expense column of the cost statement.

Stat. Auth.: [ORS 430](#).041

Stats. Implemented:

309-043-0155 Management Fees

(Effective 12/11/1981)

Management fees are an allowable expense if they are necessary, reasonable, non-duplicative of facility personnel and functions, and are documented by a binding contract with a non-related party defining the items, services and activities provided. If the administrator or assistant administrator is supplied as part of the contract, the rule governing their compensation applies and adjustments may be made. Documentation demonstrating that the services were actually performed shall be required. Management fees paid to a related organization are subject to OAR 309-043-0150.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0160 Administrator

(Effective 12/11/1981)

(1) Each facility shall employ an Administrator who meets federal ICF/MR requirements. This person must act for the facility's governing body in the overall management of the ICF/MR and arrange for an employee to be responsible for the administration of the ICF/MR at all times.

(2) No assistant Administrator salary shall be allowed in facilities with less than 59 beds. One full-time Assistant Administrator salary shall be allowed in facilities with 59 beds or over. There are no licensing or educational requirements for the Assistant Administrator.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0165 Legal and Accounting Costs

(Effective 12/11/1981)

Legal and accounting costs, which include legal and administrative actions to resolve a disagreement with the state regarding resident care shall be an allowable cost in the base cost category.

Stat. Auth.: [ORS 430](#)

Stats. Implemented:

309-043-0170 Non-Allowable Costs

(Effective 04/27/1994)

Non-allowable costs include, but are not limited to:

- (1) Bad debt expense, except as related to Title XIX recipients;
- (2) Cost of basic research (including Section 1122 of Social Security applications if rejected);
- (3) Concession and vending machine costs;
- (4) Amortization of noncompetitive agreement;
- (5) Funeral and cemetery expenses (except in FSRTF);
- (6) Goodwill;
- (7) Laboratory salaries and supplies (except in FSRTF);

- (8) Pharmacy salaries (except in FSRTF);
- (9) Physician salaries (except in FSRTF);
- (10) Religious salaries, supplies and space;
- (11) X-ray salaries and supplies (except in FSRTF);
- (12) Personal purchases;
- (13) Federal and other governmental income taxes;
- (14) Penalties and fines and related interest and bank charges other than regular service charges;
- (15) Miscellaneous expenses not related to resident care;
- (16) Donations and contributions;
- (17) Expenses for barber and beautician services not included in routine care;
- (18) Costs of services and items otherwise reimbursable through AFS Medical Programs (except in FSRTF);
- (19) Costs of services and items otherwise reimbursable through the resident's personal funds;
- (20) Compensation of officers, directors, stockholders, and others associated with a provider not related to residential care;
- (21) Interest on loans to or from owners;
- (22) Costs which have not been incurred but have been recorded in conjunction with balance sheet reserve accounts (appropriations of retained earnings), such as self-insurance cost accounts and reserve accounts. The actual allowable costs associated with these accounts shall be recognized only in the period incurred;
- (23) Key man insurance;

- (24) Assistant administrator salaries in facilities with less than 59 beds;
- (25) Advertising, except help wanted advertising;
- (26) Cash shortages;
- (27) Undocumented amounts;
- (28) Salaries not paid within 90 days after the end of the ICF/MR cost report period;
- (29) Vehicle and aircraft costs not related to facility business, to resident care and/or resident recreation;
- (30) Out-of-state travel expense except for Full Service Residential Training Facilities; in-state industry sponsored workshop or conference expenses are limited to the administrator or assistant administrator plus the director of nursing services and other staff employed in the facility;
- (31) Leasehold purchase expenses;
- (32) Employee benefits and allowances not provided to all full-time employees or their substantial equivalent;
- (33) Costs (including legal fees, accounting and administrative costs, travel costs, and costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made; and
- (34) On or after July 18, 1984, interest expense related to that portion of the acquisition price of an ICF/MR that exceeds the depreciable basis (OAR 309-043-0120) will not be reimbursable.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0175 Filing of Cost Statement

(Effective 04/27/1994)

(1) The ICF/MR Cost Statement and the Medicare Cost Form 2552 plus the MHDDSD calculation of reasonable cost form are uniform cost reports containing actual financial data from operation of ICF/MR facilities. Full Service Residential Training Facilities shall fill out the Medicare Cost Form and Calculation of Reasonable Cost. All other facilities shall report financial data on the ICF/MR Cost Statement in accordance with instructions provided by the Division. FSRTFs will follow the guidelines provided with the Medicare Form 2552:

(a) Gross costs and revenues on the cost reports shall agree with the statement of earnings and expenses or profit and loss statement of the facility;

(b) Home office financial data on the cost reports shall be reconcilable to the home office financial statements and records;

(c) The ICF/MR Cost Statement shall be reconcilable to the appropriate IRS report and payroll tax reports.

(2) Facilities shall file proper cost statement(s) as prescribed in section (1) of this rule annually with the Division's Audit Unit reporting actual financial data experienced in the latest fiscal period of operation of the facility. These reports will be filed for less than an annual period only when necessitated by the facility terminating its agreement with the Division, change in ownership, change in program reimbursement methodology, change in fiscal period, or for special time periods as may be reasonably established by the Division. The facility should use the same fiscal period for the cost statement(s) as used for the applicable federal tax return, the two of which must be reconcilable. Cost statements are due within 90 days after the end of the normal fiscal period, change in program reimbursement methodology, change of ownership, or withdrawal from the program or special time periods as requested by the Division.

(3) A report containing false information provided by the facility, knowingly or with reason to know, shall constitute cause for termination of the facility's agreement with the Division. Facilities filing false reports may be referred for prosecution under applicable statutes.

(4) Each required cost statement shall be signed by the individual who normally signs the facility's federal income tax return. If the cost statement is prepared by someone other than an employee of the facility, the individual preparing the cost statement is also required to sign and indicate his or her relationship to the provider.

(5) ICFs/MR that are a distinct part of a facility certified to provide intermediate or skilled nursing care shall complete and submit a Nursing Home Cost Statement with the ICF/MR Cost Statement. A schedule showing the allocation between ICF/MR services and intermediate or skilled nursing care services shall be submitted with the cost statement.

(6) Improperly completed or incomplete cost statements will be returned to the facility for proper completion and shall be returned to the Division within 30 days.

(7) If the cost statement is not submitted within the required time period, the interim rate then in effect shall be reduced to the settlement rate established from the last audited or desk reviewed cost statement. If a settlement rate has not been established, then the interim rate will be reduced to the interim rate in effect prior to the last increase granted in the interim rate. The reduced interim rate shall remain in effect until the first of the month following submission of a properly completed cost statement.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)
Stats. Implemented:

309-043-0180 Rate Setting

(Effective 04/27/1994)

(1) Except as described in section (2) of this rule, the Division shall use a per diem reimbursement rate schedule to establish maximum allowable ICF/MR reimbursement rates determined by the State of Oregon to represent 100 percent of the reasonable cost of an economically and efficiently operated facility. Separate rates shall be established for each class of ICF/MR facility. The rate for a facility within each class will be based on the rate schedule and may vary depending on the number and ICF/MR class of residents in the facility. The maximum reimbursement rate for each facility shall be established by the Division by dividing 95 percent

of the facility's licensed ICF/MR bed capacity into its total per diem reimbursement rate.

(2) Full Service Residential Training Facilities shall be reimbursed using an interim rate as provided in OAR 309-043-0185(2) and settlements will be determined as described in OAR 309-043-0195(2).

(3) The Division's rate schedule will consist of two major cost categories: base cost and labor cost. OAR 309-043-0200 describes cost centers within these cost categories:

(a) Base costs for each class of ICF/MR shall be based on amounts determined by the State of Oregon to be reasonable in similar residential facilities; i.e., residential training facilities or nursing facilities which are not certified to provide ICF/MR services;

(b) Labor costs for each class of ICF/MR shall be based on requirements in the federal regulations, state licensing requirements, the state's experience in state-operated ICFs/MR, and costs determined by the State of Oregon to be reasonable in similar facilities; i.e., group care homes or nursing facilities, which are not certified to provide ICF/MR services.

(4) Except as described in section (2) of this rule, the Division's rate schedule shall be reviewed annually by reviewing each facility's cost as submitted on the ICF/MR Cost Statement and comparing actual allowable costs to the per diem reimbursement rate schedule. Based on this review, the per diem reimbursement rate schedule may be revised to assure reasonable and adequate rates consistent with efficiency, economy, and quality of care. Copies of the rate schedule for each fiscal year will be available at the Division.

(5) Settlement rates shall be established for each facility on a retrospective basis for each facility's fiscal year as provided in OAR 309-043-0195.

(6) An interim rate schedule may be established by the Division if in its judgment economic trends, interim ICF/MR Cost Statements, CPI, or other evidence indicates that the rate schedule no longer constitutes reasonable cost reimbursement:

(a) The Division may require ICF/MR facilities to submit ICF/MR Cost Statements between facilities' regularly scheduled ICF/MR Cost Statements;

(b) The Division shall give facilities 90 days notice to submit interim ICF/MR Cost Statements;

(c) Failure to submit interim ICF/MR Cost Statements shall subject the facility to penalties set forth in OAR 309-043-0175.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0185 Interim Rates

(Effective 04/27/1994)

(1) For each SRTF and LRTF, the Division develops an interim rate which is the lesser of the facility's model budget rate (a) or the facility's projected net per diem cost (b):

(a) The model budget represents 100 percent of reasonable per diem 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 percent of the facility's licensed bed capacity:

(i) The model budget rate at 100 percent occupancy is multiplied by the number of resident days at 100 percent occupancy to yield the ceiling amount in dollars;

(ii) The ceiling amount is divided by the greater of:

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

(II) 95 percent 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 provider's cost statement.

(b) 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 diem reimbursement rate schedule for subsequent periods. Adjustments have historically fallen into four categories:

(A) Correction 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;

(E) 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 diem reimbursement rate schedule for subsequent periods. The Division will consider recent data which is the equivalent of an interim cost report by the facility. 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.

(c) The facility or the Division may request a per diem rate adjustment if a significant change in allowable costs can be substantiated;

(d) 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 OAR 309-043-0195. In the year-end settlement, the Division takes into account the interim rate payments already made and compares those payments with the settlement rate.

(2) For each FSRTF, the interim rate shall be based on the facility's projected costs. Each facility shall submit their projected costs, and rationale for the projections, to the responsible Title XIX intermediary. The Title XIX intermediary shall review the projections, make appropriate adjustments, and approve an interim rate.

(3) The facility or the Division may request an interim rate adjustment if the basis for the prospective rate has changed and a significant change in projected costs can be substantiated.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0190 Direct Care Staff

(Effective 04/27/1994)

(1) The ICF/MR must insure that the staff are not diverted from their primary responsibilities by excessive housekeeping or clerical duties or other activities not related to resident care.

(2) Direct care staffing ratio:

(a) The following formulas are used to calculate the required number of staff when individuals are present in the facility. Changes to the direct care staffing ratio will only be made as part of a MHDDSD field audit for the purpose of determining 100 percent of an efficient and economically operated facility and determining the per diem reimbursement rate:

(A) "A" residents require a 1:2 staff to resident ratio computed as follows:

(i) 1st shift -- 1:8;

(ii) 2nd shift -- 1:8;

(iii) 3rd shift -- 1:16.

(B) "B" residents require a 1:2.5 staff to resident ratio computed as follows:

(i) 1st shift -- 1:16;

(ii) 2nd shift -- 1:8;

(iii) 3rd shift -- 1:16.

(C) "C" residents require a 1:5 staff to resident ratio computed as follows:

(i) 1st shift -- 1:32;

(ii) 2nd shift -- 1:16;

(iii) 3rd shift -- 1:32.

(b) To determine full time equivalence (FTE) in any of the staffing ratios, compute the number of staff as described above and multiply the total by a posting factor of 1.63, e.g., in a facility with 16 "A" classified residents, a total of five staff would be required for each 24-hour period. Multiply a posting factor of 1.63 by five to get 1:2 FTE ratio or eight staff required to provide 24-hour service, seven days per week;

(c) The posting factor of 1.63 is based on a 365-day year, and assumes each staff member works five days per week, and has 12 holidays per year, 12 vacation days per year, and 12 sick days per year. Based on these figures, the average staff member works 224 days per year (52 weeks x 5 days - 36 days absent), which means another person must be on duty for 141 days in order to have one person on duty in that position for 365 days per year. One hundred forty-one is 63 percent of 224. Therefore in order to have one person on duty in a given position for 365 days of the year, there must be available one plus 0.63, or 1.63 individuals, one working 224 days and the other working 141 days per year.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0195 Year-End Settlement

(Effective 04/27/1994)

(1) Settlement:

(a) The Division shall establish a year-end settlement rate on a retrospective basis for the period covered by the facility's cost statement and shall issue an official notice to the facility indicating the exact amount of the retroactive settlement;

(b) The year-end settlement rate shall be calculated as the lower of the ceiling rate or the actual net per diem cost as described in paragraphs (A) and (B) of this subsection:

(A) Ceiling rate: The facility's model budget rate will be revised to reflect the actual number and classification of residents for the period. The product of the resulting revised rate at 100 percent occupancy and the number of resident days at 100 percent 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:

(i) If the facility is occupied at 95 percent 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;

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

(B) Actual net per diem cost. The quotient of actual costs, as adjusted in accordance with this rule, and actual resident days for the period shall be the actual net per diem cost.

(c) The dollar amount of the settlement shall be the sum of the 12 products of the monthly settlement rate (less the interim rate) and the respective monthly number of ICF/MR resident days (monthly settlement rate - monthly interim rate) x (monthly ICF/MR resident days):

(A) If the result of this calculation is positive, the dollar amount shall be paid by the Division to the facility;

(B) If the result of this calculation is negative, the dollar amount shall be paid by the facility to the Division;

(C) If the result of this calculation is zero, the Division's interim rate payment shall constitute full and complete payment.

(d) Vacancies described in OAR 309-043-0070 which are not prior authorized will not be allowed in the settlement process for Small and Large Residential Training Facilities.

(2) Settlement for FSRTFs:

(a) The Division shall establish a year-end settlement rate on a retrospective basis for the period covered by the facility's cost statement and shall issue an official notice to the facility indicating the exact amount of the retroactive settlement;

(b) The settlement for Full Service Residential Training Facilities shall be calculated as follows:

(A) Actual allowable costs. Actual allowable costs shall be actual costs for the period, adjusted in accordance with these rules;

(B) Reimbursable amount. The reimbursable amount shall be actual allowable costs;

(C) The dollar amount of the settlement shall be the reimbursable amount less total Title XIX interim payments less third party resource payment for the period:

(i) If the result of this calculation is positive, the dollar amount shall be paid by the Division to the facility;

(ii) If the result of this calculation is negative, the dollar amount shall be paid by the facility to the Division;

(iii) If the result of this calculation is zero, the Division's interim payments shall constitute full and complete payment.

(3) Costs above the ceiling amount. Costs above the ceiling amount may be allowed:

(a) When an individual admitted to and residing in a privately-operated ICF/MR needs diversion or crisis services as defined in

OAR 309-041-0300 through 309-041-0335, Standards for Diversion/Crisis Services. In this situation, costs above the ceiling amount to prevent the individual from being admitted to a state-operated ICF/MR may be authorized by the Assistant Administrator for Developmental Disabilities. The costs will be reimbursed from State and Federal funds. Written prior approval from the Assistant Administrator for Developmental Disabilities must be obtained before funds are expended. Requests for reimbursement of costs above the ceiling amount must include the following information: Name of individual; definition of problems; explanation of why existing resources are insufficient to resolve the problem(s); description of goods and/or services to ameliorate the problem(s) including frequency, duration, and costs;

(b) When an individual not admitted to but residing in a privately-operated ICF/MR and occupying a vacant or reserved bed needs diversion or crisis services as defined in OAR 309-041-0300 through 309-041-0335. The facility in conjunction with the Individual Support Plan team will determine the appropriateness of serving a non-admitted individual. In this situation, any money received by the ICF/MR to prevent the individual from being admitted to a state-operated ICF/MR shall not be considered an offset to the ICF/MR payment as required by OAR 309-043-0080(7). The costs will be reimbursed from state funds. Written prior approval from the Assistant Administrator for Developmental Disabilities must be obtained before funds are expended. Requests for reimbursement of costs above the ceiling amount and without regard to OAR 309-043-0080(7) must contain the information described in subsection (a) of this section;

(c) When the costs are related to the approved plan for additional services as described in subsections (a) and (b) of this section. Documented costs must be submitted on an invoice and included with the facility's annual costs statement. These costs will be considered in the settlement process.

(4) Appeals. The Division shall notify the facility of the year-end settlement by certified letter. If the facility wishes to appeal the settlement, the facility shall so notify the Division in writing within 15 days of receipt of the letter of notification. Letters of appeal must be postmarked within the 15-day limit. Letters of appeal must be addressed to the Assistant Administrator for

Administrative Services. The Assistant Administrator, Administrative Services, will forward all appeals to the Manager of the Mental Health and Developmental Disability Services Division's Audit Section for initial consideration. If no resolution is forthcoming, the provider will be given an opportunity for a fair hearing of the issues before the Assistant Administrator, Administrative Services.

(5) Monetary recovery, sanction, or other appeals. A provider may appeal the Division's proposed action by letter within the same 15-day period as allowed for appeals above: address this letter to the Assistant Administrator, Administrative Services.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stats. Implemented:

309-043-0200 Base and Labor Costs

(Effective 04/27/1994)

Facilities, except FSRTFs which may utilize the Medicare chart of accounts, shall use the following accounts to classify expenses on the ICF/MR Cost Statement.

(1) Base Costs: These accounts are for costs other than salaries and consulting fees:

(a) General and Administrative:

(A) 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;

(B) 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 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;

(C) Acct. 3520 -- Management Fees: Management fees as defined in OAR 309-043-0155 are to be included in this account;

(D) Acct. 3530 -- Donated Services: Donated services by nonpaid workers as defined in OAR 309-043-0145 are to be included in this account;

(E) Acct. 3610 -- Communications: Telephone and telegraph expenses are to be included in this account;

(F) 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 non-allowable expense;

(G) 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;

(H) 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;

(I) 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;

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

(K) Acct. 3810 -- Advertising and Public Relations: Advertising and public relations expenses are to be included in this account;

(L) Acct. 3820 -- Licenses and Dues: License and dues expenses are to be included in this account;

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

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

(O) Acct. 3910 -- Miscellaneous: This account includes general and administrative expenses not otherwise includable in the General and Administrative Cost Area.

(b) Shelter:

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

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

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

(D) Acct. 4620 -- Rent: Rent attributable to the lease of a facility is to be included in this account;

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

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

(G) Acct. 4710 -- Depreciation -- Land Improvements: See OAR 309-043-0115 and 309-043-1020 regarding capital assets and depreciation;

(H) Acct. 4720 -- Depreciation -- Building: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(I) Acct. 4730 -- Depreciation -- Building Equipment: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(J) Acct. 4740 -- Depreciation -- Moveable Equipment: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(K) Acct. 4750 -- Depreciation -- Leasehold Improvements: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(L) Acct. 4809 -- Interest: Interest attributable to the purchase of facility and equipment is to be included in this account;

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

(c) Utilities:

(A) Acct. 5610 -- Heating Oil: Heating oil expense is to be included in this account;

(B) Acct. 5620 -- Gas: Gasoline for autos is to be included in Travel -- Motor Vehicles. All other gasoline is to be included in this account;

(C) Acct. 5630 -- Electricity: Electricity expense is to be included in this account;

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

(d) Laundry:

(A) Acct. 6310 -- Laundry Supplies: Laundry supplies expense is to be included in this account;

(B) Acct. 6315 -- Linen and Bedding: Linen and bedding expense is to be including in this account;

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

(D) Acct. 6910 -- Miscellaneous: This account includes laundry costs not otherwise includable in the laundry area.

(e) Housekeeping:

(A) Acct. 7310 -- Housekeeping Supplies: Housekeeping supplies expense is to be included in this account;

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

(f) Dietary:

(A) Acct. 8310 -- Dietary Supplies: This account includes expenses associated with the serving of food, such as utensils, paper goods, dishware and other items. This account combines all the cost 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 snackbar are to be included in the expense account Concession Supplies;

(B) Acct. 8410 -- Food;

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

(g) Nursing Supplies and Services:

(A) Acct. 9310 -- Nursing Supplies: This account includes cost of supplies used in nursing care covered in OAR 309-043-0045;

(B) Acct. 9320 -- Drugs and Pharmaceuticals Non-RX: This account includes costs of drugs and pharmaceuticals defined in OAR 309-043-0045;

(C) Acct. 9330 -- Drugs and Pharmaceuticals -- RX: This account includes drug prescription costs defined in OAR 309-043-0050;

(D) Acct. 9351 -- Pharmacy Services and Supplies: Pharmacy supplies and outside services expenses are to be included in this account;

(E) Acct. 9352 -- Laboratory Services and Supplies: Laboratory Supplies and outside services expenses are to be included in this account;

(F) Acct. 9353 -- X-Ray Services and Supplies: X-ray supplies and outside services expenses are to be included in this account;

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

(H) Acct. 9355 -- Rehabilitation Supplies and Services: Rehabilitation supplies and outside services expenses are to be included in this account;

(I) Acct. 9510 -- Physician Fees: Outside Physician fees are to be included in this account;

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

(K) Acct. 9950 -- Concession Supplies: This account includes costs associated with vending machines and similar resale items;

(L) Acct. 9955 -- Barber and Beauty Shop: This account includes barber and beauty related costs. Costs of services and supplies not meeting the definition in OAR 309-043-0045(2)(g), shall be adjusted;

(M) Acct. 9960 -- Funeral and Cemetery: Funeral and cemetery expenses are to be included in this account;

(N) Acct. 9965 -- Personal Purchases: This account includes the costs of all items purchased for resident care and excluded in the OAR 309-043-0045 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 OAR 309-043-0060, authorized for payment from resident funds, and items not routinely furnished to all residents without additional costs;

(O) Acct. 9990 -- Miscellaneous: This account includes miscellaneous supplies and services not otherwise includable in the Nursing Supplies and Services Cost Area.

(2) Labor Costs:

(a) Payroll Taxes and Employee Benefits: These accounts are to include all payroll taxes and employee benefits. The total net allowable payroll taxes and employee 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:

(A) Acct. 3200 -- Total Employee Benefits and Taxes: This account is the total of Acct. 3210, Total Payroll Taxes, and Acct. 3220, Employee Benefits;

(B) Acct. 3210 -- Total Payroll Taxes: This account includes the payroll taxes FICA, Acct. 3211; State Unemployment, Acct. 3212; Federal Unemployment, Acct. 3213; Worker's Compensation, Acct. 3214; Tri-Met, Acct. 3215; and any others;

(C) Acct. 3211 -- FICA: This account includes the FICA tax;

(D) Acct. 3212 -- State Unemployment: This account includes the state unemployment insurance tax;

(E) Acct. 3213 -- Federal Unemployment: This account includes the federal unemployment insurance tax;

(F) Acct. 3214 -- Worker's Compensation: This account includes the Worker's Compensation insurance tax;

(G) Acct. 3215 -- Tri-Met: This account includes the Tri-Met payroll tax;

(H) Acct. 3216 -- Payroll Tax -- Other: Any amount showing in this account must be identified;

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

(b) Administrative Salaries:

(A) 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;

(B) Acct. 3231 -- Employee Benefits and 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 the Acct. 3200, Total Employee Benefits and Taxes.

(c) Other Administrative Salaries:

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

(B) 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 allowable 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 to another payroll account;

(C) Acct. 3132 -- 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.

(d) Nursing Salaries:

(A) Acct. 9110 -- Salaries -- DNS: Director of Nursing Services salary is to be included in this account;

(B) Acct. 9111 -- Salaries -- RN: Registered Nurse salaries are to be included in this account;

(C) Acct. 9112 -- Salaries -- LPN: Licensed Practical Nurse and Licensed Vocational Nurse salaries are to be included in this account;

(D) Acct. 9291 -- Employee Benefits and Taxes: This account shall include employee benefits and taxes for the DNS, RNs, and LPNs. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(e) Direct Care Salaries:

(A) 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;

(B) Acct. 9123 -- Salaries -- Direct Care Supervisors: Salaries for direct care supervisors;

(C) Acct. 9124 -- Salaries -- Secure Ward Staff: Salaries for secure ward staff;

(D) Acct. 9125 -- Salaries -- Secure Ward Supervisors: Salaries for secure ward supervisors;

(E) 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.

(f) Other Salaries:

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

(B) Acct. 6110 -- Laundry Salaries: Laundry salaries are to be included in this account;

(C) Acct. 7110 -- Housekeeping Salaries: Janitorial salaries and housekeeping salaries are to be included in this account;

(D) Acct. 8110 -- Dietary Salaries: Dietary salaries are to be included in this account;

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

(F) Acct. 9131 -- Salaries -- Pharmacy: Pharmacy salaries are to be included in this account;

(G) Acct. 9132 -- Salaries -- Laboratory: Laboratory salaries are to be included in this account;

(H) Acct. 9133 -- Salaries -- X-Ray: X-ray salaries are to be included in this account;

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

(J) Acct. 9135 -- Salaries -- Rehabilitation: Rehabilitation salaries are to be placed in this account;

(K) Acct. 9140 -- Salaries -- Religious: Religious salaries are to be included in this account;

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

(M) 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;

(N) Acct. 9296 -- Employee Benefits and Taxes: This account includes benefits and taxes for the employee listed in the cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(g) Active Treatment Services: These accounts include all special programs except Day Program service costs incurred by FSRTFs, and professional medical services, except Medical Service costs incurred by FSRTFs. Included are costs for consultation, treatment and evaluations not paid for separately by AFS. Expenses not required for certification shall be adjusted as non-allowable:

(A) Acct. 9150 -- Qualified Mental Retardation Professional;

(B) Acct. 9151 -- Registered Nurse Consultant (SRTF only);

(C) Acct. 9152 -- Psychologist;

(D) Acct. 9153 -- Social Worker;

(E) Acct. 9154 -- Speech Therapist;

(F) Acct. 9156 -- Occupational Therapist;

(G) Acct. 9157 -- Recreation Therapist;

(H) Acct. 9158 -- Physical Therapist;

(I) Acct. 9159 -- Dietician;

(J) Acct. 9160 -- Dentist;

(K) Acct. 9161 -- Pharmacist;

(L) Acct. 9162 -- Skill Trainer/Program Coordinator (Skill Trainer in SRTF only);

(M) Acct. 9170 -- Other Medical Consultants;

(N) 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.

(h) Medical Services: These accounts include only medical service program costs incurred by FSRTFs:

(A) Acct. 9180 -- Physician Services;

(B) Acct. 9181 -- Pharmacy Services;

(C) Acct. 9182 -- Laboratory Services;

(D) Acct. 9183 -- X-Ray Services;

(E) Acct. 9186 -- Nursing Services;

(F) Acct. 9187 -- Dental Services;

(G) Acct. 9188 -- Central Supply Services;

(H) Acct. 9298 -- Employee Benefits and Taxes: This account includes benefits and taxes for the employee included in this cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(i) Day Program Services: These accounts include only Day Program service costs incurred by FSRTFs:

(A) Acct. 9190 -- Day Program Services;

(B) 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.

Stat. Auth.: [ORS 179](#) & [ORS 430](#)

Stat. Implemented: