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Narrative Explanation of Nursing Facility Reimbursement Formula

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into eleven sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arm's length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The

cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in the Kansas Administrative Regulations.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2022, 2023, and 2024.

If the current provider has not submitted a calendar year report during the base cost period, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in the Kansas Administrative Regulations.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to December 31, 2023. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center

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upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with the Kansas Administrative Regulations.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Global Market Intelligence, National Skilled Nursing Facility Market Basket Without Capital Index (S&P Index). The S&P indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

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Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2022-2024. If base cost data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Index. The S&P indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding the base cost data period.

All cost data used to set rates for facilities reentering the program shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Index. The S&P indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider.

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Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.20, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.20 (Set D01) case mix indices developed by the Centers for Medicare and Medicaid Services (CMS) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

Rates will be adjusted for case mix twice annually using case mix data from the two quarters preceding the rate effective date. The case mix averages used for the rate adjustments will be the simple average of the case mix averages for each quarter. The resident listing cut-off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

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Rate Effective Date:	Cut-Off Dates for Quarterly CMI:
July 1	January 1 and April 1
January 1	July 1 and October 1

The resident listings will be mailed to providers prior to the dates the semi-annual case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected

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cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to December 31, 2025. The inflation will be based on the S&P Global Market Intelligence, CMS Nursing Home without Capital Market Basket index.

The S&P Global Market Intelligence, CMS Nursing Home without Capital Market Basket Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the S&P index.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost

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center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full-time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, “Statement of Owners and Related Parties.” This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2024 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service-based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner

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administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service-based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2025.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to December 31, 2025. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based

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on the IHS Global Insight, CMS Nursing Home without Capital Market Basket Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

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The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the statewide average CMI for the cost report year by the facility's cost report period CMI, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are eight million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $80 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be $104 (**D**=130% x $80).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The facility's Medicaid CMI is determined by averaging the facility average Medicaid CMI from the two quarters preceding the rate effective data. The Medicaid CMI is then divided by the statewide average CMI for the cost data period. Finally, this result, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation:

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The facility's direct health care per diem cost is $80.00, the Direct Health Care per diem limit is $104.00 and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $80.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the answer by the Allowable Direct Health Care Cost. In this case that would result in $72.00 (0.9000/1.0000 x $80.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next quarter rose to 1.1000, the Medicaid Acuity Adjustment would be $88.00 (1.1000/1.0000 x $80.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real And Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

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Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in (K.A.R. 30-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in (K.A.R. 129-10-25). The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $3.00 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.50 per diem add-on. Providers that achieve a staff retention rate at or above the 75th percentile will earn a $2.50 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a staff retention rate lower than the 75th percentile but that increase their staff retention rate by 10% or more will receive a per diem add-on of $0.50 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a Medicaid occupancy percentage of 65% or more will receive a $0.75 per diem add-on. Finally, providers that maintain quality measures at or above the 75th percentile will earn a $1.25 per diem add on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

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i. Case Mix Adjusted Nurse Staffing Ratio

The case mix adjusted nurse staffing ratio component of the incentive factor is determined by taking each nursing facility's total direct health care hours per resident day and is case mix adjusted to the period statewide average. The 75th percentile staff ratio based on the 2017 Medicaid cost reports is 5.14. Therefore, nursing facilities with a total staffing ratio of 5.14 or higher will receive the staff ratio per diem add-on of $3.00. Homes that are below 5.14, but that have improved the staff ratio 10 percent or more over the previous year, will receive a per diem add-on of $0.50.

ii. Staff Retention Rate

The staff retention rate component of the incentive factor is derived from each nursing facility's total retention percentage from Schedule J of the 2017 Medicaid cost report. The 75th percentile base on the 2017 cost reports is 72 percent. Therefore, nursing facilities with a total retention rate of 72 percent or higher and less than 10 percent contract labor, will receive the staff retention rate per diem add-on of $2.50. Nursing facilities with a total retention rate below 72 percent, but that have improved the staff retention ratio by 10 percent or more over the previous year, and have less than 10 percent contract labor will receive a per diem add-on of $0.50.

iii. Medicaid Occupancy Percentage

The Medicaid occupancy percentage component of the incentive factor is determined by calculating each nursing facility's Medicaid occupancy percentage using Medicaid days and resident days from the Medicaid cost report. The threshold is set at 65 percent, therefore, nursing facilities with a Medicaid occupancy rate of 65 percent or higher will receive the Medicaid occupancy percentage per diem add-on of $0.75.

iv. The Quality Measures based on the CMS Nursing Home Compare Program

The quality measures component of the incentive factor is determined by each nursing facility's performance on nine long-stay quality measures assessed by the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare program. The nine measures included in the scoring are:

- Decline in Late-Loss ADLs
- Decline in Mobility on Unit
- High-Risk Residents with Pressure Ulcers
- Moderate to Severe Pain
- Antipsychotic Medications
- Falls with Major Injury
- Physical Restraints

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- Indwelling Catheter
- Urinary Tract Infection

The scoring for each quality measure is determined by the point values CMS assigns based on facility performance relative to the national distribution for the quality measure. CMS assigns a point value of 20, 40, 60, 80, or 100 to each measure. The total quality score for each facility is calculated by summing the points for each of the nine quality measures. The highest total quality measure score for the incentive factor is 900. Additional information about how CMS assigns point values for each measure can be found in the Nursing Home Compare Technical Users' Guide, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

The FY 2019 quality measures scores were determined from the CMS Nursing Home Compare Dataset: 2016Q4 – 2017Q3 which includes all assessment data from October 1, 2016 through September 30, 2017. The 75th percentile quality measures score based on this dataset is 640. Homes with a total quality measures score of 640 or higher will receive the quality measures per diem add-on of $1.25.

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The table below summarizes the incentive factor outcomes and per diem add-ons:

INCENTIVE OUTCOME	INCENTIVE FACTOR PER DIEM
CMI adjusted staffing ratio >= 75th percentile (5.80), or CMI adjusted staffing < 75th percentile but improved >= 10%	$3.00 $0.50
Staff retention rate >= 75th percentile, 69% or Staff retention rate < 75th percentile but increased >= 10% Contracted labor < 10% of total direct health care labor costs	$2.50 $0.50
Medicaid occupancy >= 65%	$0.75
Quality Measures >=75th percentile (600)	$1.25
Total Incentive Add-ons-Available	$7.50

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero ($0.00) to seven dollars and fifty cents ($7.50). It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider’s rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.50, which is 120% of the statewide NFMH median of 2.92. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.21, which is 110% of the statewide NFMH median. Providers with staffing

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Narrative Explanation of Nursing Facility Reimbursement Formula

ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. The provider will earn a point if their per diem operating expenses are below $33.71, or 90% of the statewide median of $37.45.

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 52%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 52% but equal to or below 75%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 76%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 76%, but at or above 67%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.50) of NF-MH median (2.92), or CMI adjusted staffing ratio between 110% (3.21) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $33.71, 90% of NF-MH median, $37.45	1
Staff turnover rate <= 75th percentile, 52% Staff turnover rate <= 50th percentile, 75% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 76% Staff retention >= 50th percentile, 67%	2, or 1
Total Incentive Points Available	8

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Narrative Explanation of Nursing Facility Reimbursement Formula

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The Culture Change/Person-Centered Care Incentive Program

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes nine different incentive levels to recognize homes that are either pursuing culture change, have made major achievements in the pursuit of culture change, have met minimum competencies in person-centered care, have sustained person-centered care, or are mentoring others in person-centered care.

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first six levels (Level 0 – Level 5) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home.

Level 6 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 7 and Level 8 are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

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LEVEL & PER DIEM INCENTIVE	SUMMARY OF REQUIRED NURSING HOME ACTION	INCENTIVE DURATION
LEVEL 0: The Foundation $0.50 Per Medicaid Resident Per Day (PMRPD)	Home completes a self-evaluation tool according to the enrollment instructions. Home participates in all required activities noted in the Foundation timeline and Workbook. Homes that do not complete the requirements at this level must sit out for the remainder of the program year. At successful completion of the Foundation level, homes move to Level 1.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year, provided the home participates in program activities. Homes' incentive may be dropped mid-year for non-participation. Receipt of incentive also based on survey eligibility.
LEVEL 1: 0-2 Cores $0.75 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 1 incentive by passing the Foundation level and/or sustaining practices in 1-2 cores. Level 1 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 2: 3-4 Cores $1.00 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 2 incentive by passing and/or sustaining 3-4 cores. Level 2 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.

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LEVEL 3: 5-6 Cores $1.25 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 3 incentive by passing and/or sustaining 5-6 cores. Level 3 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 4: 7-8 Cores $1.50 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 4 incentive by passing and/or sustaining 7-8 cores. Level 4 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 5: 9-11 Cores $1.75 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 5 incentive by passing and/or sustaining 9-11 cores. Level 5 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.

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LEVEL 6: 12 Cores Person-Centered Care Home $2.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 6 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices). The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 6.	Available beginning July 1 following confirmed minimum competency of person-centered practice. Incentive is granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 7: 12 Cores Sustained Person-Centered Care Home $2.50 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 7 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 7.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies in all 12 PEAK cores for the second consecutive year. Incentive is granted for two fiscal years. Renewable biannually. Receipt of incentive also based on survey eligibility.
LEVEL 8: 12 Cores Mentor Home $3.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 8 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years and meeting the minimum mentoring activities, as directed in the mentoring log. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices bi-annually and turning in a mentor log. KDADS will make final determination of movement to level 8.	Available beginning July 1 following confirmation of mentor home standards (upkeep of minimum person-centered care competencies in all 12 PEAK cores and mentoring points). Incentive is granted for two fiscal years. Renewable bi-annually. Receipt of incentive also based on survey eligibility.

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Survey and Certification Performance Adjustment

The survey and certification performance of each NF and NF-MH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive factor payment a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that are in compliance within 30 days of the survey, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor. The survey and certification review period will be the 12-month period ending one quarter prior to the incentive eligibility review date. The following table lists the incentive eligibility review dates and corresponding review period end dates.

Incentive Eligibility Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 129-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) Retroactive Rate Adjustments

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Narrative Explanation of Nursing Facility Reimbursement Formula

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

INFLATION TABLE
EFFECTIVE 07/01/25

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-21	06-21	0.941	12-25	1.147	21.892%
01-22	07-21	0.958	12-25	1.147	19.729%
02-22	08-21	0.958	12-25	1.147	19.729%
03-22	09-21	0.958	12-25	1.147	19.729%
04-22	10-21	0.971	12-25	1.147	18.126%
05-22	11-21	0.971	12-25	1.147	18.126%
06-22	12-21	0.971	12-25	1.147	18.126%
07-22	01-22	0.990	12-25	1.147	15.859%
08-22	02-22	0.990	12-25	1.147	15.859%
09-22	03-22	0.990	12-25	1.147	15.859%
10-22	04-22	1.010	12-25	1.147	13.564%
11-22	05-22	1.010	12-25	1.147	13.564%
12-22	06-22	1.010	12-25	1.147	13.564%
01-23	07-22	1.029	12-25	1.147	11.467%
02-23	08-22	1.029	12-25	1.147	11.467%
03-23	09-22	1.029	12-25	1.147	11.467%
04-23	10-22	1.039	12-25	1.147	10.395%
05-23	11-22	1.039	12-25	1.147	10.395%
06-23	12-22	1.039	12-25	1.147	10.395%
07-23	01-23	1.052	12-25	1.147	9.030%
08-23	02-23	1.052	12-25	1.147	9.030%
09-23	03-23	1.052	12-25	1.147	9.030%
10-23	04-23	1.062	12-25	1.147	8.004%
11-23	05-23	1.062	12-25	1.147	8.004%
12-23	06-23	1.062	12-25	1.147	8.004%
01-24	07-23	1.077	12-25	1.147	6.500%
02-24	08-23	1.077	12-25	1.147	6.500%
03-24	09-23	1.077	12-25	1.147	6.500%
04-24	10-23	1.082	12-25	1.147	6.007%
05-24	11-23	1.082	12-25	1.147	6.007%
06-24	12-23	1.082	12-25	1.147	6.007%
07-24	01-24	1.092	12-25	1.147	5.037%
08-24	02-24	1.092	12-25	1.147	5.037%
09-24	03-24	1.092	12-25	1.147	5.037%
10-24	04-24	1.103	12-25	1.147	3.989%
11-24	05-24	1.103	12-25	1.147	3.989%
12-24	06-24	1.103	12-25	1.147	3.989%
01-25	07-24	1.107	12-25	1.147	3.613%
02-25	08-24	1.107	12-25	1.147	3.613%
03-25	09-24	1.107	12-25	1.147	3.613%
04-25	10-24	1.113	12-25	1.147	3.055%
05-25	11-24	1.113	12-25	1.147	3.055%
06-25	12-24	1.113	12-25	1.147	3.055%

* = (Midpoint of rate period index / Midpoint of rye index) -1

COST CENTER LIMITATIONS EFFECTIVE 07/01/25

COST CENTER	UPPER LIMIT
Operating	$60.48
Indirect Health Care	$73.49
Direct Health Care	$200.30 *
Real and Personal Property Fee	$10.69

* = Base limit for a facility average case mix index of 1.2921

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/25

NF ONLY

	INCENITVE OUTCOME	INCENTIVE AMOUNTS
1)	CMI adjusted staffing ratio >= 75th percentile (5.80), or	$3.00
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.50
2)	Staff retention rate >= 75th percentile, 69% or	$2.50
	Staff retention rate < 75th percentile but increased >= 10%	$0.50
	Contracted labor < 10% of total direct health care labor costs	
3)	Medicaid occupancy >= 65%	$0.75
4)	Quality Measures >= 75th percentile (600)	$1.25
	Total Incentive Available	$7.50

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/25

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.50) of NF-MH median (2.92), or CMI adjusted staffing ratio between 110% (3.50) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $33.71, 90% of NF-MH median, $37.45	1
4	Staff turnover rate <= 75th percentile, 52% Staff turnover rate <= 50th percentile, 75% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 76% Staff retention >= 50th percentile, 67%	2, or 1
	Total Incentive Points Available	8

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

PEAK INCENTIVE FACTOR EFFECTIVE 07/01/18

Level & Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 0 The Foundation $0.50	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 must return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes must start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.

Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $2.50	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level 5 Person-Centered Care Mentor Home $3.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

Owner/Related Party Salary Limitations Effective 07/01/2023

Job Classification		Salary Range **	**Bed Capacity** 0-59	**60-120**	**121+**	**0-99**	**100**	**Any Size**
Administrator	*	23	37,003					
	*	28		47,258				
	*	31			54,683			
Co-Administrator	*	19	30,493					
	*	22		35,235				
	*	24			38,896			
Accountant II		25						40,872
Attorney II		33						60,382
Bookkeeper (Accounting Specialist)		20						31,990
Secretary II (Administrative Specialist)		20						31,990
Gen. Maint. & Repair Tech Senior		18						29,016
Physical Plant Supervisor		24						38,896
Physical Plant Supervisor Senior		26						42,806
Cook Senior		18						29,016
Food Service Supervisor Senior		19						30,493
Housekeeping/Laundry Worker		18						29,016
Director of Nursing (RN Administrator)	*	35						66,518
Registered Nurse	*	29						49,650
Licensed Practical Nurse (LPN)	*	20						31,990
LPN Senior	*	21						33,613
Health Care Assistant (CNA II)	*	18						29,016
Licensed Mental Health Technician		18						29,016
Physical Therapist II	*	27						45,032
Physical Therapist Aide		18						29,016
Occupational Therapist II	*	26						42,806
Speech Pathologist/Audiologist I	*	26						42,806
Activity Therapy Tech.		18						29,016
Activity Therapist I	*	23						37,003
Social Worker Specialist	*	25						40,872
Medical Records Administrator		24						38,896
Medical Records Technician		19						30,493
Central Office Staff (3+ Facilities)								
Chief Executive Officer		36						69,784
Chief Operating Officer		34						63,357
All Other Chief Officers		31						54,683

* License/Registration/Certificate Requirement
** Step 7 of the salary range has been used to set the limits.

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/2025

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	FY	Amount	Cost of Living State Emp.
15	5,475	$25,308	$4.62	80	11,781	4.250%
16	5,840	29,606	$5.07	81	12,617	7.100%
17	6,205	33,904	$5.46	82	13,248	5.000%
18	6,570	38,202	$5,81	83	14,109	6.500%
19	6,935	42,500	$6.13	84	14,426	2.250%
20	7,300	46,798	$6.41	85	15,147	5.000%
21	7,665	51,096	$6.67	86	15,933	5.190%
22	8,030	55,394	$6.90	87	16,411	3.000%
23	8,395	59,692	$7.11	88	16,575	1.000%
24	8,760	63,990	$7.30	89	17,238	4.000%
25	9,125	68,288	$7.48	90	17,755	3.000%
26	9,490	72,586	$7.65	91	18,021	1.500%
27	9,855	76,884	$7.80	92	18,021	0.000%
28	10,220	81,182	$7.94	93	18,111	0.500%
29	10,585	85,480	$8.08	94	18,202	0.500%
30	10,950	89,778	$8.20	95	18,407	1.125%
31	11,315	94,076	$8.31	96	18,591	1.000%
32	11,680	98,374	$8.42	97	18,591	0.000%
33	12,045	102,672	$8.52	98	18,777	1.000%
34	12,410	106,970	$8.62	99	19,059	1.500%
35	12,775	111,268	$8.71	00	19,250	1.000%
36	13,140	115,566	$8.79	01	19,250	0.000%
37	13,505	119,864	$8.88	02	19,683	2.250%
38	13,870	124,162	$8.95	03	19,683	0.000%
39	14,235	128,460	$9.02	04	19,978	1.500%
40	14,600	132,758	$9.09	05	20,577	3.000%
41	14,965	137,056	$9.16	06	20,834	1.250%
42	15,330	141,354	$9.22	07	21,355	2.500%
43	15,695	145,652	$9.28	08	21,782	2.000%
44	16,060	149,950	$9.34	09	22,327	2.500%
45	16,425	154,248	$9.39	10-18	22,327	0.000%
46	16,790	158,546	$9.44	19	22,941	2.750%
47	17,155	162,844	$9.49	20	23,515	2.500%
48	17.520	167.142	$9.54	21-23	24,103	2.500%
49	17.885	171.440	$9.59	24-25	25,308	5.000%
50	18,250	175,738	$9.63			

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/14

90th Percentile PPD
Administrator & Co-
Administrator Salary.

CASE MIX INDEX TABLE EFFECTIVE 07/01/08

RUG-III GROUP	CODE	CMI
EXTENSIVE SERVICES		
Extensive Special Care 3 / ADL>6	SE3	2.10
Extensive Special Care 2 / ADL>6	SE2	1.79
Extensive Special Care 1 / ADL>6	SE1	1.54
SPECIAL REHABILITATION		
Rehab all levels / ADL 17-18	RAD	1.66
Rehab all levels / ADL 14-16	RAC	1.31
Rehab all levels / ADL 10-13	RAB	1.24
Rehab all levels / ADL 4-9	RAA	1.07
SPECIAL CARE		
Special Care / ADL 17-18	SSC	1.44
Special Care / ADL 15-16	SSB	1.33
Special Care / ADL 4-14	SSA	1.28
CLINICALLY COMPLEX		
Clinically Complex w/ Depression / ADL 17-18	CC2	1.42
Clinically Complex / ADL 17-18	CC1	1.25
Clinically Complex w/ Depression / ADL 12-16	CB2	1.15
Clincally Complex / ADL 12-16	CB1	1.07
Clinically Complex w/ Depression / ADL 4-11	CA2	1.06
Clincally Complex / ADL 4-11	CA1	0.95

RUG-III GROUP	CODE	CMI
IMPAIRED COGNITION		
Cognitive Impairment w/ Nursing Rehab / ADL 6-10	IB2	0.88
Cognitive Impairment / ADL 6-10	IB1	0.85
Cognitive Impairment w/ Nursing Rehab / ADL 4-15	IA2	0.72
Cognitive Impairment / ADL 4-5	IA1	0.67
BEHAVIOR PROBLEMS		
Behavior Problem w/ Nursing Rehab / ADL 6-10	BB2	0.86
Behavior Problem / ADL 6-10	BB1	0.82
Behavior Problem w/ Nursing Rehab / ADL 4-5	BA2	0.71
Behavior Problem / ADL 4-5	BA1	0.60
REDUCED PHYSICAL FUNCTIONS		
Physical Function w/ Nursing Rehab / ADL 16-18	PE2	1.00
Reduced Physcial Function / ADL 16-18	PE1	0.97
Physical Function w/ Nursing Rehab / ADL 11-15	PD2	0.91
Reduced Physcial Function / ADL 11-15	PD1	0.89
Physical Function w/ Nursing Rehab / ADL 9-10	PC2	0.83
Reduced Physical Function ADL 9-10	PC1	0.81
Physical Function w/ Nursing Rehab / ADL 6-8	PB2	0.65
Reduced Physical Function ADL 6-8	PB1	0.63
Physical Function w/ Nursing Rehab / ADL 4-5	PA2	0.62
Reduced Physcial Function / ADL 4-5	PA1	0.59

MAR - 5 2009

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/2025

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	53.26	61.10	140.99	10.18	265.53	54.98	63.90	154.08	10.18	283.14
MEAN	54.94	63.76	149.15	15.79	283.64	57.54	67.59	162.14	15.79	303.05
WTMN	55.00	63.11	147.37	17.30	282.77	56.89	66.27	160.31	17.30	300.77
# OF PROV	294					294				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/25

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & C0-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	418,552	20.67	89,053	6.26	418,552	20.67	93,778	8.18
99th	418,552	20.67	89,053	6.26	281,228	20.67	93,778	8.18
95th	160,459	10.97	89,053	6.26	165,532	11.12	90,592	4.36
90th	143,681	9.61	89,053	6.26	145,756	9.63	58,107	3.90
85th	130,809	9.00	68,494	2.71	131,722	9.00	56,411	3.81
80th	125,066	8.28	68,494	2.71	125,066	8.30	56,346	3.46
75th	119,943	7.95	68,494	2.71	120,221	7.95	42,899	3.40
70th	115,124	7.59	68,494	2.71	115,526	7.59	36,336	3.27
65th	110,842	7.07	63,254	2.45	111,370	7.11	35,032	2.83
60th	108,490	6.61	63,254	2.45	108,914	6.77	33,644	2.70
55th	105,084	6.21	48,878	2.45	106,033	6.23	33,520	2.56
50th	102,268	5.83	48,878	2.45	102,794	5.96	33,512	2.55
40th	94,893	5.15	48,643	1.94	95,777	5.29	31,821	1.69
30th	87,520	4.46	48,643	1.94	88,358	4.47	27,480	1.53
20th	77,935	3.93	48,183	0.98	79,319	3.94	24,537	1.49
10th	59,949	3.00	2,578	0.42	60,078	3.09	22,941	1.22
1st	15,973	0.87	2,578	0.42	15,973	0.87	18,864	0.83
LOW	0	0.00	2,578	0.42	1,216	0.06	18,864	0.00
MEAN	103,237	6.27	52,726	2.46	98,553	6.33	39,329	2.62
WTMN	91,702	5.40	54,883	2.22	88,724	5.47	35,514	2.24
# of Prov	289		7		289		21	

COMPILATION OF NF
INCENTIVE POINTS AWARDED
EFF. 07/01/2025

NURSING FACILITY

INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	51	18.0%
$0.50	17	6.0%
$0.75	47	16.5%
$1.00	1	0.4%
$1.25	34	12.0%
$1.75	7	2.5%
$2.00	23	8.1%
$2.25	0	0.0%
$2.50	25	8.8%
$3.00	38	13.4%
$3.25	6	2.1%
$3.50	1	0.4%
$3.75	15	5.3%
$4.25	5	1.8%
$4.50	1	0.4%
$4.75	1	0.4%
$5.00	2	0.7%
$5.50	6	2.1%
$6.25	2	0.7%
$6.75	1	0.4%
$7.50	1	0.4%
TOTALS	284	100%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	191	67.3%
$0.50	13	4.6%
$0.75	41	14.4%
$1.00	9	3.2%
$1.25	4	1.4%
$1.50	6	2.1%
$1.75	2	0.7%
$2.00	2	0.7%
$2.50	6	2.1%
$3.00	10	3.5%
TOTALS	284	100.0%

COMPILATION OF NF-MH
INCENTIVE POINTS AWARDED
EFF. 07/01/2025

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	0	0.0%
1	1	10.0%
2	6	60.0%
3	1	10.0%
4	0	0.0%
5	1	10.0%
6	0	0.0%
7	1	10.0%
8	0	0.0%
TOTALS	10	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	9	90.0%
$0.50	0	0.0%
$0.75	1	10.0%
TOTALS	10	100.0%

June 10, 2025

« NAME», Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«PROV_NUM»01
KMAP ID #: «EDS_PROV_N»

Dear « NAME»:

The per diem rate shown on the enclosed Case Mix Payment Schedule for state fiscal year 2026 (FY26) has been forwarded to the Managed Care Organizations (MCOs) for processing of future reimbursement payments. The rate will become effective July 1, 2025 and is based on final revised rates posted to the Kansas Register on June 12, 2025 https://sos.ks.gov/publications/Kansas-register.html.

The Kansas Department for Aging and Disability Services (KDADS), administers the Medicaid nursing facility services payment program on behalf of Kansas Department of Health and Environment (KDHE). The rate was calculated by applying the applicable Medicaid program policies and regulations, to the cost report (Form MS 2004) data shown on the enclosed payment schedule.

If you do not agree with this action, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. The request for fair hearing shall be in writing and delivered to or mailed to the agency so that it is received by the **Office of Administrative Hearings, 1020 S. Kansas Ave., Topeka, KS 66612-1311** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if you received this letter by mail). Failure to request or pursue such an appeal in a timely manner may adversely affect your rights.

If you have questions about the adjustments, please contact Shirley Chung at (785) 296-6457 or email at Shirley.Chung@ks.gov. For questions on the Medicaid Rate, please contact Trescia Power at (785) 368-6685 or email at Trescia.Power@ks.gov or Steven Hime at (785) 296-2535 or email at Steven.Hime@ks.gov.

Sincerely,

Sheri Jurad
Director of NF/ACH Programs
Kansas Department for Aging and Disability Services

Kansas Medicaid / MediKan

Case Mix Schedule
1st - 2nd QTR 2026 ANNUAL

Current Provider Information

KDADS Provider Number:	KMAP Provider Number:	1st QTR Medicaid CMI:	1.0762
Facility Name:	Area/County:	2nd QTR Medicaid CMI:	1.0346
Address:		Average Medicaid CMI:	1.0554 (a)
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/2022	12/31/2023	12/31/2024	
Inflation Factor:	13.564%	8.004%	3.989%	
Facility Cost Report Period CMI:	1.1593	1.1675	1.1241	
Statewide Average CMI:	1.3388	1.2120	1.3256	1.2921 [b]
NF Or NF/MH Beds:	30	30	30	
Bed Days Available:	10,950	10,950	10,980	
Inpatient Days:	7,436	8,661	8,700	
Occupancy Rate:	67.9%	79.1%	79.2%	
Medicaid Days:	4,878	4,162	4,223	
Calc Days If Appl:	9,308	9,308	9,333	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$1,006,188	$1,015,959	$927,872		
Cost Report Adjustments:	($7,038)	$6,371	$24,662		
O/A Limit Adjustment:	$0	($74,168)	$0		
Total Adjusted Costs:	$999,150	$948,162	$952,534		
Total Inflated Adjusted Costs:	$1,134,675	$1,029,989	$990,531		
Total Combined Base Cost:				$3,155,195	
Days Used In Division Oper:	7,436	8,661	8,700	24,797	
				127.24	Oper Per Diem
				60.48	Oper Per Diem Cost Limitation
				60.48	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$766,733	$875,361	$909,752		
Cost Report Adjustments:	($6,084)	($6,395)	($24,662)		
Total Adjusted Costs:	$760,649	$868,966	$885,090		
Total Inflated Adjusted Costs:	$863,823	$938,518	$920,396		
Total Combined Base Cost:				$2,722,737	
Days Used In Division IDHC:	7,436	8,661	8,700	24,797	
				109.80	IDHC Per Diem
				73.49	IDHC Per Diem Cost Limitation
				73.49	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$1,423,941	$1,664,370	$1,763,442		
Cost Report Adjustments:	($220)	$0	$0		
Rapid Response Staffing Grant Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$1,423,721	$1,664,370	$1,763,442		
Total Inflated Adjusted Costs:	$1,616,835	$1,797,586	$1,833,786		
Total CMI Adjusted Costs:	$1,867,177	$1,866,102	$2,162,500		
Total Combined Base Cost:				$5,895,779	
Days Used In Division DHC:	7,436	8,661	8,700	24,797	
				237.76	Case Mix Adjusted DHC Per Diem
				200.30	DHC Per Diem Cost Limitation
				200.30	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	163.61	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

208.82	Real and Personal Property Fee
0.00	Inflation (0.000%)
0.00	RPPF Rebase Add On
208.82	RPPF Before Limit
10.69	RPPF Limitation
10.69	Allowable RPPF (4)

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		308.27
Incentive Factor		5.50
PEAK 2.0		1.50
Bed Tax Adjustment		2.82
Medicaid Add-On		20.00
Minimum Wage Adjustment		0.00
Total Medicaid Rate Effective	**07/01/2025**	**338.09**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

KDADS Provider Number:
KMAP Provider Number:

Facility Name:

Rate Effective Date: 07/01/25

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above the NF 75th Percentile (5.80)	$ 3.00		$ 3.00
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.50		$ 0.00
		6.24	
Cost Report Year Data:		12/31/2024	
2. Staff Retention			
Tier 1: At or Below the NF 75th Percentile (69%)	$ 2.50		$ 0.00
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10%	$ 0.50		$ 0.00
And Contract Nursing Labor Less than 10% of total DHC Labor Costs (Contract Labor 17%)		59%	
Cost Report Year Data:		12/31/2024	
3. Occupancy Rate			
Medicaid Occupancy At or Above 65%	$ 0.75	61%	$ 0.00
Cost Report Year Data:		12/31/2024	
4. Quality Measures			
Score At or Above 75th Percentile (600)	$ 1.25		$ 1.25
		620	
Total Incentive before Survey Adjustment			$ 4.25
0%			$ 0.00
Final Incentive Awarded			**$ 4.25**
Peak 2.0 Incentive	$ 3.00		$ 0.50
Peak 2.0 Survey Adjustment and Reduction 0%			$ 0.00
Final PEAK 2.0 Incentive Awarded			**$ 0.50**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

KDADS Provider Number:
KMAP Provider Number:

Facility Name:

Rate Effective Date: 07/01/25

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above 120% of NF-MH Median (3.50)	2		2
Tier 2: At or Above 110% of NF-MH Median of (3.21)	1		0
(NF-MH Median is 2.92 for an Average Statewide CMI of 1.2921)			
		3.65	
Cost Report Year Data:		12/31/2024	
2. Operating Expense			
At or Below 90% of NF-MH Median ($33.71)	1	$30.71	1
Cost Report Year Data:		12/31/2024	
3. Staff Turnover			
Tier 1: At or Below the NF-MH 75th Percentile (52%)	2		0
Tier 2: At or Below the NF-MH 50th Percentile (75%)	1		1
And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (0%)			
		68%	
Cost Report Year Data:		12/31/2024	
4. Staff Retention			
Tier 1: At or Below the NF-MH 75th Percentile (76%)	2		0
Tier 2: At or Below the NF-MH 50th Percentile (67%)	1		0
		80%	
Cost Report Year Data:		12/31/2024	
5. Occupancy Rate			
Total Occupancy At or Below 90%	1		1
		76%	
Cost Report Year Data:		12/31/2024	
Total Points Awarded			**5**

Incentive Before Survey Adjustment		$5.00
Survey Adjustment and Reduction	100%	($5.00)
Final Incentive		**$0.00**

Scoring:

Points	Per Diem
6 - 8	$7.50
5	$5.00
4	$2.50
0 - 3	$0.00

PEAK 2.0 Incentive		$0.00
Survey Adjustment and Reduction	100%	$0.00
Total PEAK 2.0 Incentive		**$0.00**

Kansas Statutes Annotated 39-708c. Powers and duties of secretary of social and rehabilitation services; . . . centralized payment of welfare expenditures. (a) The secretary of social and rehabilitation services shall develop state plans, as provided under the federal social social security act, whereby the state cooperates with the federal government in its program of assisting the states financially in furnishing assistance and services to eligible individuals. The secretary shall undertake to cooperate with the federal government on any other federal program providing federal financial assistance and services in the field of social welfare not inconsistant with this act. The secretary is not required to develop a state plan for participation or cooperation in all federal social security programs or other federal programs that are available. The secretary shall also have the power, but is not required to develop a state plan in regard to assistance and services in which the federal government does not participate.

. . .

(k) All contracts shall be made in the name of "secretary of social and rehabilitation services," and in that name the secretary may sue and be sued on such contracts. The grant of authority under this subsection shall not be construed to be a waiver of any rights retained by the state under the 11th amendment to the United States constitution and shall be subject to and shall not supersede the provisions of any appropriations act of this state.

. . .

(x) The secretary shall establish payment schedules for each group of health care providers. Any payment schedules which are a part of the state medicaid plan shall conform to state and federal law. The secretary shall not be required to make any payments under the state medicaid plan which do not meet requirements for state and federal financial participation.

(1) The secretary shall consider budgetary constraints as a factor in establishing payment schedules so long as the result complies with state and federal law.

(2) The secretary shall establish payment schedules for providers of hospital and adult care home services under the medicaid plan that are reasonable and adequate to meet the costs

which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The secretary shall not be required to establish rates for any such facility that are in excess of the minimum necessary to efficiently and economically meet those standards regardless of any excess costs incurred by any such facility.

. . .

KANSAS MEDICAID STATE PLAN

*Substitute per letter dated 8/28/01 *

Attachment 4.19 D
Part I
Subpart C
Exhibit C-7
Page 1 of 1

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Nursing Facility Rate Determination To Comply With Court Order

Effective May 10, 1993, payment will be made in accordance with the Memorandum and Order entered May 10, 1993, and the Order entered May 28, 1993, and any subsequent orders by the United States District Court of the District of Kansas in Case Number 93-4045-RDR.

1. Being reviewed as to when pulled from state plan per CMS 179 for KS 06-06 shows this page is not part of state plan. (Tim Weidler is checking on).