the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of audit, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including revenue cost findings, is omitted.

F. Where to File

The cost report and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

the cost report. In addition, the Division of Medicaid would prepare an "Annual" case mix report to determine the case mix score for the cost report period. A "Quarter Final" case mix report would be prepared to determine the case mix score for each quarter beginning with the quarter July 1, 2000 through September 30, 2000. The facility's rates for the period August 15, 2000 through December 31, 2001 would be calculated using actual cost and census data from the August 15 through October 31 cost report, after desk review. The case mix reports would also be used in calculating the rates. The initial Quarter Final case mix score would be used for the rate periods beginning August 15, 2000; October 1, 2000; and January 1, 2000. The following quarters' rates would be set on the normal schedule using the quarter Final roster score from the second preceding quarter.

P. Out-of-State Providers

For services not available in Mississippi, Nursing Facilities, PRTFs ICF/IIDs and swing beds from states other than Mississippi may file claims for services provided to Mississippi Medicaid beneficiaries that are

new beds, replaced beds, renovated beds, or for depreciation expense.

d. Assets less than $5,000.

Assets purchased for an amount less than $5,000 should be included in allowable costs as a current period expense.

Additionally, the portion of assets allocated to the certified unit for less than $5,000 should be expensed in the current period. The expense should be included in the Miscellaneous Administrative and Operating Costs on the cost report.

e. Facility depreciation.

A facility may choose to depreciate an asset that cost less than $5,000 or was allocated at less than $5,000. In these cases, the Division of Medicaid will not adjust the depreciation expense nor enter an adjustment to allow the asset as an expense in the cost report period. Similarly, the provider should not adjust depreciation expense and expense these assets, for cost report purposes only, either. However, if the provider chooses to do so, a separate depreciation schedule, for Medicaid purposes only, must be prepared and submitted with these expensed assets removed. Additionally, the capitalized asset will not be used for comparison to the new bed value to determine depreciation type. Only assets greater than or equal to $5,000 are used for the comparison.

8. Dues.

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs. Some of those organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicaid purposes the allowable costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (A) professional, technical or business related; (B) civic; and (C) social, fraternal, and other. The Division of Medicaid will look to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.