

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HUMAN SERVICES

THE AIME J. FORAND BUILDING

600 NEW LONDON AVENUE

CRANSTON, RI 02920

PRINCIPLES OF REIMBURSEMENT

FOR

NURSING FACILITIES

EFFECTIVE SEPTEMBER 1, 2004

PRINCIPLES OF REIMBURSEMENT

TN 04-007 Approval date _____ Effective 09/01/2004

MEDICAID
PRINCIPLES OF REIMBURSEMENT
TABLE OF CONTENTS

	<u>Page</u>
APPLICABLE STATE AND FEDERAL LAWS	I
INTRODUCTION TO PRINCIPLES OF REIMBURSEMENT	II
RECORDS RETENTION	III
GENERAL:	1
Reporting	1
Reasonable Costs	1
Upper Limits	2
Annual Cost Report BM-64	2
Admission Policy	3
Participation and Payments	4
Method for Determining Cost Center Ceilings	4
Method for Determining Individual Prospective Rates	8
Temporary Rates for Newly Constructed Facilities	10
Appeals Process	11
Appeal Requests for Rate Increments	
12	
Payments	15
Record keeping	16
Adequacy of Cost Information	16
Census Data	17
Audit of Provider Costs	17

	<u>Page</u>
OPERATING COSTS	
Property Payment – Fair Rental Value System	19
Transportation Vehicles	25
Real Estate and Personal Property Taxes	26
Personnel Costs	26
Compensation of Owners	26
Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals	26
Compensation of Administrators 27	
Facilities Operated by Members of a Religious Order	28
Professional Services	28
Fringe Benefits	28
Other Operating Costs	30
Accounting and Auditing Fees	30
Routine Services	30
Educational Activities	31
Physicians' Fees	31
Conference Expenses	31
Medicine Chest Supplies, Transportation, and Laundry Expenses	32
Insurance	32
Start-up Costs	33
COST NOT RELATED TO PATIENT CARE	33
SERVICE AND AFFILIATED ORGANIZATIONS	
General	36
Reporting Requirements	36
HOME OFFICE CHARGES	37

	<u>Page</u>
Changes in Bed Capacity	38
Excess Bed Capacity	38
Transactions Which Reduce Reported Cost of Patient Care	39
Refunds, Discounts, and Allowances	39
Quality of Care and Cost Incentives	
40	
Ventilator Beds	

APPENDIX

(A) Base Year and Audit Scheduling	41
(B) Administrator's Compensation	42
(C) Routine Services and Supplies	43
(D) Chart of Accounts	46
(F) Historical Cost Indexes	51

PRINCIPLES OF REIMBURSEMENT

APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966, under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97 which was enacted by the Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40, Chapter 8 of the Rhode Island General Laws, 1956, as amended.

The Powers of the Director

Rhode Island General Laws 40-8-13 provides that the Director of the Department of Human Services, shall make and promulgate rules, regulations, and fee schedules, for the proper administration of the Medical Assistance Program, and to make the Department's State Plan for Medical Assistance conform to the provisions of the Federal Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4 and 40-8.2-7 of the Rhode Island General Laws and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Chapter 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

INTRODUCTION

It should be noted that commencing with the 1978 calendar year, the Rhode Island Medical Assistance Program began to make payment to participating facilities on a prospective basis.

Starting on October 1, 2003 the Department will begin to phase in provisions for rate reform to be completed on or before October 1, 2005. This rate reform will include the following elements:

Annual base years from every three years.

Four cost centers from seven cost centers.

Establishment of new cost center ceilings.

Re-array of costs of all facilities in the Direct Labor Cost Center (combined Labor Related and O.B.R.A. effective October 1, 2003) every three years.

Re-array of costs of all facilities in the Other Operating Cost Center (combined All Other and Management Cost Centers effective October 1, 2005) every three years.

Establishment of a Fair Rental System to replace the Other Property Related Cost Center effective September 1, 2004.

Establishment of a Pass Through Cost Center (combined Fixed Property, Energy and Insurance from the All Other Cost Center effective October 1, 2003) with no cost center ceiling.

This per diem reimbursement rate will represent full and total payment for services provided and, except for changes as a result of an audit of the facility's base year, appeal period or direct labor cost interim adjustment payment, will not be subject to a retrospective adjustment to reflect increases or decreases in actual costs.

III

RECORDS RETENTION AS PROVIDED FOR BY THE STATUTE OF LIMITATIONS

(12-12-17)

Each provider of long term care services participating in the Title XIX Medical Assistance Program in accordance with the provisions of these Principles of Reimbursement will maintain within the State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual BM-64 Cost Report. However, original invoices, canceled checks, contracts, minutes of board of directors meetings and any other material used in the preparation of the annual cost report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with the State Agency as required by the Statute of Limitation. Each provider will make available upon request such records and all other pertinent records to representatives of the State Agency, representatives of the Federal Department of Health and Human Services, and the State's Medicaid Fraud Unit within the State's Attorney General Office.

The State Agency will maintain all cost reports submitted by providers and all audit reports prepared by the Agency for at least ten (10) years after the month in which the cost report was filed by the provider or at least ten (10) years after the month in which the audit was conducted.

These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the State's Administrative Procedures Act.

IV

The State will pay to participating providers of long term care facility services who furnish services in accordance with the requirements of the Principles of Reimbursement

the amount determined for services furnished by the provider under said Principles of Reimbursement.

If an overpayment to a participating provider of long term care services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by Section 40-8.2-22 of the Rhode Island General Laws.

GENERAL

REPORTING

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who are eligible for nursing facility services in accordance with Medicaid regulations relating to resources and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement, through application of rate ceilings, provide for payment of Nursing Facility Care services under the Medicaid Program on a prospective basis through rates that are reasonable and adequate to meet costs that must be incurred by efficiently and economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those cost of an individual facility for items, goods and services which, when compared, will

not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein, the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public or the federal upper payment limit for such services. The Upper Payment Limit is based on reasonable cost as is our payment.

Annual Cost Report BM-64

All facilities must file an annual cost report BM-64 on a calendar year. The report format is determined by the Center for Adult Health's Rate Setting Unit and must be filed on or before March 31 following the close of the year.

Newly constructed facilities will be allowed a temporary rate subject to the submission to the Chief Long Term Care Reimbursement of a BM-64 cost report covering a six-month period from the beginning of operations. The rate will be determined in the manner described for all other facilities under these principles and subject to the same ceilings.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the BM-64 on time without written authorized extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis until said BM-64 is submitted or facility is terminated from the program for failure to file BM-64 report within six months from the close of the reporting year.

A final BM-64 must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

ADMISSION POLICY

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws, patients shall have the right to remain in a facility after the depletion of private funds.

PARTICIPATION AND PAYMENTS

Facilities and at least 25% of all their nursing facility beds must be dually certified for participation in both the Federal Medicare - Title XVIII Program and the Rhode Island Medical Assistance - Medicaid Title XIX Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

The Director of the Department of Human Services may waive the requirement for Medicare certification upon his or her determination, upon consultation with the director of the state surveying agency, that: (1) there is an imminent peril to public health, safety or welfare; and/or (2) it is in the best interest of the state and the residents of the facility.

METHOD FOR DETERMINING COST CENTER CEILINGS

NOTE: Effective for October 1, 2003, there is a continuation of the calculation of the ceilings for two cost centers. This calculation will continue until September 30, 2005 for the Management and All Other Cost Centers.

On September 1, 2004, the Other Property Related Cost Center will be replaced by the Fair Rental Value System in the Property Cost Center, Reimbursement for that cost center will be such that a ceiling will not be calculated. Effective October 1, 2005, ceilings for the Management and All Other Cost Center will be replaced by a ceiling for the Other Operating Cost Center. The Other Operating Cost Center ceiling will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the

median for facilities for the most current array year.

BM-64 Cost Reports for calendar year 1991 for all certified and participating nursing facilities in continuous operation from January 1, 1991 through December 31, 1991, will be grouped into one level of care category and allowable cost per diems will be arrayed in descending order into the following two cost center per diem groupings: (a) All Other Expenses, and (b) Management Related Expenses. The appropriate percentiles as specified below will then be applied to this arrayed data and will be increased by the annual percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services for rate years 1992 and 1993 and each subsequent July 1 beginning with the percentage adjustment recognized July 1, 1994,

BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for the Hospital Based Skilled Nursing Facilities) will be grouped and allowable cost per diems will be arrayed in descending order into the Direct Labor Cost Center. The appropriate percentile, 125% of the median for Direct Labor, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services effective July 1, 2003 and then each subsequent October 1st. Costs in the Direct Labor Cost Center will be arrayed every three years, the next array year being calendar year 2005 to establish a new maximum effective October 1, 2006.

The Pass Through Cost Center is such that a ceiling maximum is not calculated.

a. **Pass Through Items:**

This cost center grouping will include allowable costs reported in all account numbers as listed in Appendix 'E' – Chart of Accounts. Costs will be allowed without regard

to a ceiling maximum. Each facility will report in Account No. 8470 the expenditure for the Health Care Provider Assessment. The costs in this item attributable to program revenue received will be fully recognized for reimbursement through an add-on to the per diem rate equal to the Health Care Provider Assessment as compounded.

b. **Direct Labor:**

This cost center grouping will include allowable costs in all account numbers as listed in Appendix 'E' – Chart of Accounts. Costs will be allowed up to a ceiling maximum of 125% of the median of the costs of all facilities arrayed.

Nursing facilities whose allowable 2002 direct labor costs are below the median in the direct labor cost center may make application to the Department's Rate Setting and Auditing Unit for a direct labor cost interim payment adjustment equal to twenty-five (25%) of the amount such allowable 2002 direct labor costs are below the median. This interim payment adjustment will be granted on or after October 1, 2003. The interim payment adjustment must be expended on expenses allowable within the direct labor cost center and any portion of the interim payment not expended on allowable direct labor cost center expenses will be subject to retroactive adjustment and recoupment by the Department. The Department will determine the final direct labor payment adjustment after review of the facility's actual direct labor expenditures. The final direct labor payment adjustment will be included in the facility's October 1, 2004 rate until the facility's next base year.

c. All Other Expenses:

NOTE: This cost center grouping will be combined with the Management cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.

This cost center grouping will include all other allowable costs not specifically covered by grouping a, b, d Costs will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities arrayed until October 1, 2005.

d. Management Related Expenses:

NOTE: This cost center grouping will be combined with the All Other Expenses cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.

This cost center grouping will include all allowable costs reported in Accounts No. 7411-Administrator, 7412 - Officers/Owners, 7421 - Other Administrative Salaries, 7431 - Health Care Plan (Employer's share-portion attributable to personnel included within this cost center), 7432 - Other Employee Fringe Benefits (portion attributable to personnel included within this cost center), 7433 - Home Office/Central Services (portion attributable to labor and payroll-related expenses), 7435 - Computer Payroll/Data Processing Charges, 7436 - Accounting/Auditing Fees, 7437 - Legal Services, 7440 - Payroll Taxes (portion attributable to personnel included within this cost center), 7442 - Insurance (Workers

Compensation, group life, pension and retirement-portion attributable to personnel included within this cost center), 7444A -Utilization Review Medicaid Title XIX, 7449A - Miscellaneous Management Related, 7523 - Dietary Consultant, 7712 - Pharmacists Salaries/Fee and effective September 1, 1996 cost will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities until October 1, 2005.

METHOD OF DETERMINING INDIVIDUAL PROSPECTIVE RATES

Note: Due to the changes to the Principles of Reimbursement effective October 1, 2003, certain rate calculations remain in effect until October 1, 2005. This applies to the Other Property Related Cost Center, (until September 1, 2004), All Other Cost Center and Management Cost Center. These calculations are listed in numbers 1 through 5.

1. Each facility in operation during calendar year 1991 shall have its base year established in accordance with 'Appendix A' Audit Scheduling for all cost centers described in a., b., c., d above. Any facility commencing operation subsequent to calendar year 1991, shall have its first six months of operation as its base period.

2. Effective July 1, 1993, each facility will be assigned interim prospective rates utilizing the facility's base year BM-64 cost report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the audited year up to and including rate year 1993 and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index

adjustment of nine-tenths of one percent (.9%) effective July 1, 1999 and subject to cost center maximums described in c., d., above. The interim prospective per diem rate will be adjusted, if necessary, through results of an audit of base year costs.

3. An additional interim per diem rate will be calculated and added to each nursing facility rate to recognize reimbursement for expenditure in account #8470 Health Care Provider Assessment for Rhode Island Medical Assistance Program revenue.

4. Starting with the reporting year 1991 and with every reporting year thereafter, one-third of the participating facilities will have a new base year. The prospective rate of each facility with a new base year will be recalculated after the completion of an audit and will be effective July 1 of the year subsequent to the year in which the audit was scheduled.

The recalculated rate will reflect the actual allowable costs as determined by the audit updated by the National Nursing Home Input Price Index percentage increase(s) for the year(s) subsequent to the audited year, and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999, to produce the prospective rate; provided, however, that the new prospective rate does not exceed the maximum rates established for each cost center ceiling.

5. Commencing with the State fiscal year beginning July 1, 1994 and each State fiscal year thereafter, excluding however the rate year July 1, 1996 through June 30, 1997, the annual percentage increase will be applied to all cost centers determine new cost center ceilings. Commencing July 1, 1994, excluding however the rate year July 1, 1996 through June 30, 1997, individual facility cost center rates will be adjusted annually by the amount of percentage change in the National Nursing Home Input Price Index for the

twelve (12) month period ending the previous March. The amount of percentage change to be utilized will be the index as projected by the Centers for Medicare and Medicaid Services on the first date it is available in the month of May each year. Although the index may be obtained initially by telephone, it will be confirmed in writing.

6. Effective October 1, 2003 for the Direct Labor and Pass Through Items Cost Center, each facility will be assigned interim prospective rates utilizing the facility's base year 2002 BM-64 Cost Report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the base year. Each facility will have a new interim rate assigned each October 1st in these two (2) cost centers, based on the immediate prior calendar year cost report, increased by the recognized percentage change applied as of July 1. The interim prospective per diem rate will be adjusted, if necessary, through results of a field audit of base year costs for the Direct Labor and Pass Through Items Cost Center.

Temporary Rates for Newly Constructed Facilities

Newly constructed facilities will be allowed a temporary reimbursement rate after supplying the Chief Long Term Care Reimbursement sufficient cost data or other information necessary to fairly calculate interim per diem rates, subject to the maximum cost center ceilings. Upon completion of a six-month period from time of licensure, the facility will complete and file with the Chief Long Term Reimbursement for Nursing Facilities, a cost report form BM-64 covering the first six months of operations. Based upon

the analysis of the report and Principles of Reimbursement in effect at the time of licensure, a new rate may be calculated, subject to the maximum cost center ceilings as established, and made retroactive to the date of licensure

Proforma cost data and BM-64 cost reports covering the first six month of operations submitted by newly constructed facilities will not be considered in the array of cost information for the determination of the maximum allowable base in each of the cost center category.

APPEALS PROCESS

NOTE: This section on appeals process will be amended effective October 1, 2005 to include a provision that it shall apply to demonstrated errors made during the rate determination process.

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit results or rate assignment file a written request for a review conference to be conducted by the Associate Director, Division of Health Care, Quality, Financing and Purchasing, or other designee assigned by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The

Associate Director or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associate Director or the designee appointed by the Director of the Department of Human Service's will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

APPEAL REQUESTS FOR RATE INCREMENTS

NOTE: This section on appeal requests with the exception of item f. is hereby repealed in its entirety effective October 1, 2005.

In those cases in which the assigned prospective rate of a facility falls below the new aggregate ceiling maximum, the Department of Human Services can consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. In order to qualify for such a rate increment, demonstrated increased costs must be a result from:

- a. Demonstrated errors made during the rate determination process,
- b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff specifically mandated by the Rhode Island Department of Health,
- c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with Fire Safety Codes and/or Certification requirements of the Rhode Island Department of Health, or,
- d. Significant increases in Workers Compensation and/or Health Insurance

premiums which cannot be accommodated within the facility's assigned aggregate per diem rate will be allowed a rate increment, if cost justified, so long as the new assigned per diem rates in the Labor Related Expenses cost center and in the Management Related Expenses cost center do not exceed two-percent (2%) of said cost center ceilings, or,

e. Extraordinary circumstances, including, but not limited to, acts of God, and inordinate increases in energy costs (e.g., federal BTU tax, regional or national energy crisis). Inordinate increases in energy costs will be immediately reflected in increased rates above the energy cost center ceiling maximum. Provided, however, that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

Initial requests for prospective rate adjustments in excess of those that would be established through application of established percentage increase, will first be reviewed by the Rate Setting Unit within the Center for Adult Health within the Department of Human Services. This Unit will be empowered to grant such variances, provided that the facility involved meets the above criteria and provides all the necessary data.

Requests for rate increments will be limited to one request per annum per facility for the factors specified in items (b) (c) and (d) above. However, additional requests involving a recurring per diem increase in excess of one percent of the facility's previously assigned aggregate per diem rate will also be reviewed. Before a facility files for a rate increment, increases in operating costs addressed in (b) (c) and (d) above must have been incurred for at least a three-month period in order to establish proof of such increase.

All costs, including salaries, must be absorbed within these group ceilings. The total ceiling maximum will be the sum total of the cost center ceilings.

f. In addition to the above appeal requests, a facility may qualify for a rate increment

adjustment, as determined by the department, in accordance with this subsection:

(a) The facility is located in a federally designated Enterprise Community; and

(b) The facility is incurring allowable costs in one or more cost centers in excess of the allowable maximum for such cost center(s); and

(c) The facility files a written request for a rate increment with the department which must include the following documentation:

i. A cost containment and revenue enhancement plan; and

ii. A cost report for the most recently completed six (6) months of operations; and

iii. Such other documents as may be requested by the department.

The department shall review the written request and may grant a rate increment adjustment to become effective not earlier than the month the request was filed which:

1. may result in a per diem rate which shall not exceed the aggregate of all cost center maximums, plus the per diem rate to recognize reimbursement for the health care provider assessment in account #8470; and

2. will be limited for a period not to exceed twenty-four (24) consecutive months; and the facility may reapply for a rate increment adjustment under this subsection for a period of twenty-four (24) consecutive months following the month of expiration or termination of an approved rate increment adjustment; and

3. subject to the aggregate limit in (1) above, may recognize reasonable and necessary costs incurred by the facility to achieve the cost containment/revenue enhancement plan approved by the department; and

4. will be established for an initial six (6) month period, and may be extended and adjusted by the department for an additional six (6) month periods (but not to exceed the overall maximum twenty-four (24) month limit); and

5. will be subject to continuing review and monitoring by the department and such terms and conditions to be specified by the department in a rate increment approval letter (for initial and extended periods) to the facility.

Rate adjustments granted as a result of a request filed within 120 days after the costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to State only days.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is

prohibited.

RECORDKEEPING

Adequacy of Cost Information

Providers of Long Term Care under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.). All records must be physically maintained within the State of Rhode Island.

Census Data

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports and shall be the denominator used in the computation for determining per diem rates providing that said patient days are equal to or greater than 98% of the statewide average occupancy rate of the prior calendar year. In calculating patient days the date of admission is counted as one day, however, the date of death or discharge is not counted as a day.

AUDIT OF PROVIDER COSTS

In accordance with 45 CFR-250.30 p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial

and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs. Costs of new construction may be audited by the State as herein described. Services and affiliated organizations where common ownership exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups.

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

OPERATING COSTS

Property Payment – Fair Rental Value System (FRV)

The property payment effective September 1, 2004 will be a Fair Rental Value System (FRV) which will provide a payment in lieu of the Other Property Related Cost Center. This will eliminate reimbursement for depreciation, interest, rent, and/or lease payments on property, plant and equipment, working capital interest, all other interest, and vehicle depreciation and/or lease payments. The Fair Rental Value System (FRV) establishes a facility's value based on its age. The older the facility, the less its value. Additions and renovations (subject to a minimum per bed limit) and bed replacements will be recognized by lowering the age of the facility and, thus increasing the facility's value. The facility's established value is not affected by sale or transfer and new facilities will be assigned a rate based upon a completed survey. All Fair Rental Value Surveys are subject to field audit.

The Fair Rental Value System payment rate received by a facility as of September 1, 2004 shall be no lower than the Other Property Related Cost Center payment rate received as of June 30, 2004.

The parameters of the Fair Rental Value System and the start up of the system are as follows:

1. The initial age of each nursing facility participating in the Medicaid Program and used in the FRV calculation shall be determined as of September 1, 2004 utilizing a statewide survey to determine each facility's year of construction and date of entry into the Medicaid program. In addition, this age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built.

2. A bed value, based on a standard facility size of 450 square feet per bed, will be determined using the R.S. Means Building Construction Data Publication or a comparable valuation system adjusted by the location index for Providence, Rhode Island. The bed value for September 1, 2004 is determined to be \$ 66,000. per bed. This value per bed includes an amount of \$4,000. per bed for equipment.
3. The value will be increased by a factor of 10% to approximate the cost of land and other soft costs.
4. For each facility, the trended value will be depreciated, except for the value portion assigned as land, at a rate of 1.5% per year based upon the weighted age of the facility. Bed replacements, additions and renovation shall lower the weighted average age of the facility. The maximum age of a nursing home shall not exceed 35 years.
5. The value assigned shall be trended forward annually to the mid point of the rate year (starting July 1, 2005) based on the percentage change in the R. S. Means Construction Cost Index, or comparable index, for the previous calendar year end.
6. A nursing facility's Fair Rental Value (FRV) is calculated by multiplying the facility's current value per bed times the number of licensed (including beds approved as out of service) times a rental factor. The rental factor will be the 20-year Treasury Bond Rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk factor of 3.0 percent with an imposed floor of 9.0 percent and a ceiling of 12.0 percent. The rental factor to be utilized for September 1, 2004 will be 9.0 percent. The first recalculation of the rental factor will occur effective July 1, 2005.

7. The calculated Fair Rental Value (FRV) shall be divided by patient days for the cost reporting period. Patient days are based upon the higher of the actual census or 98% of the statewide average for all facilities included in the Fair Rental Value calculation. For start up of the Fair Rental Value System, this is considered to be calendar year 2002 for FRV rate assignment effective September 1, 2004. For rate calculations July 1, 2005 and subsequent, the census will be predicated on the previous calendar year.
8. The age of each facility will be further adjusted each July 1, to make the facility one year older, up to the maximum age, and to reduce the age for those facilities that have completed and placed into service major renovations, bed additions or replacements.
9. As previously noted, the age of each facility is adjusted for major renovations, bed additions and replacements. These changes will be averaged into the age of the facility the July 1st following the year the major renovations were placed in service or year beds were placed in service. Major renovations are defined as a project, or series of projects, with capitalized cost equal to or greater than \$1000. per bed. This is calculated on a calendar year basis.
10. Continued explanation and examples of the Fair Rental Value System (FRV) are as follows:
- A. Facility of 120 beds, constructed in 1994, with no major renovations or bed additions and occupancy of 95.0%.
- | | |
|----------------|------------|
| Value per bed | \$ 66,000. |
| Number of beds | 120. |

Value (value per beds x beds)	\$ 7,920,000.
Accumulated Depreciation (1.5% x 10 yrs. = 15.0%)	\$ 1,188,000.
Net Value (value less accumulated depreciation)	\$ 6,732,000.
Land Value (10% x value per bed x # of beds)	\$ 792,000.
Total Value	\$ 7,524,000.
Fair Rental Value Return (total value x 9.0%)	\$ 677,160.
Fair Rental Value Per Diem Rate(41,610 patient days)	\$ 16.27

- B. Example of bed addition – The addition of beds will require a computation on the weighted average age of the facility based on the construction dates of the original facility and the additional beds placed in service.

Facility of 120 beds, constructed in 1994, which added 40 beds in 1999.

Beds	Age	Weighted Average
120	5 (1999-1994)	600
40	0	0
160		3.75

New Base year 1995 (1999 – 3.75)

As compared to 1999

- C. Renovation or major improvement – The cost of major renovations and improvements are factored into a facility's age provided that they meet the definition that it is a project with capitalized cost equal to or greater than \$1,000. per bed. This is based on a calendar year basis. Renovation/improvement cost must be documented through cost reports, depreciation schedules, etc. and are subject to audit. Costs must be capitalized in order to be considered a renovation or improvement. Individual assets with a cost of

\$500.00 or more and a useful life of at least 3 years must be capitalized. Useful lives for assets acquired after September 1, 2004 are determined by utilizing the American Hospital Association (AHA) guidelines of Depreciable Hospital Assets, 1998 edition or subsequent. Assets acquired in quantity at a total cost of \$1,000. or more and multiple purchases of similar individual assets during a reporting period must be capitalized if the useful life is three years or more. In establishing the age of a facility, renovations/improvements are converted into an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility. The equivalent number of new beds will be determined by dividing the project cost by the construction cost of a new bed in the year of the renovation/improvement project. Refer to Appendix 'E' for historical cost data indexes.

Example : Facility of 120 beds, constructed in 1994 and had a major renovation project totaling \$1,000,000. in 2000.

Cost of renovation \$1,000,000. divided by replacement cost index in 2000 of \$60,443. equals 16.54 beds (figure cannot exceed total number of beds).

Beds	Age	Weighted Average
16.54	0	0
<u>103.46</u>	6	620.76
120.00		620.76
		5.17

New base year 1995, as compared to 2000.

D. Replacement of Beds – The replacement of existing beds will result in an adjustment to the age of the facility. A weighted average age will be calculated according to the year of

initial construction and the year of bed replacement. This differs from the addition of beds in that a certain number of beds have replaced those that were initially constructed. If a facility has a series of additions or replacements, it is assumed that the oldest beds are ones being replaced.

Example: Facility of 120 beds, constructed in 1984, replaced 40 beds in 1999.

Beds	Age	Weighted Average
40	0	0
80	15	1200
120		1200
		10.00

New base year 1989 (As compared to 1999)

Transportation Vehicles

The allowance for expenditures , including but not limited to, gas, oil, repairs, insurance, taxes on vehicles used to transport patients and for other official business purposes is based on the following schedule:

NUMBER OF BEDS	VEHICLES ALLOWED
35 or less	1 vehicle
36 - 75	1 1/2 vehicle
over 75 beds	maximum of 2 vehicles

Recreation vans (RV) - no allowance will be recognized.

1-4 Passenger sports auto-no allowance will be recognized.

Travel log(s) must be maintained for each vehicle in which a reimbursement allowance is recognized showing vehicle identification number, date, driver, beginning and ending odometer readings, passenger names, except for group activities when the number of patients must be recorded, destination and purpose of travel. If the travel logs indicate less than 100% nursing facility business use, only the percentage attributable to nursing facility business use will be recognized.

Expenditures for gas, oil, repairs of transportation vehicles will be allowable to the extent of the number of vehicles permissible under the principles. However, in all cases, the Department of Human Services reserves the right to make the determination of entitlement based upon the facts in each instance. The number of Medicaid patients and the nature of the service provided by a facility will be considered in this determination.

REAL ESTATE AND PERSONAL PROPERTY TAXES

For Medicaid purposes, the allowable real estate and personal property taxes will be the four quarterly amounts due and payable during the reporting year or the tax based upon the assessed valuations of the prior December 31. For example, the amount allowable for calendar year 2001 will be the four quarterly installments due and payable during calendar year 2001 or the total tax based on the December 31, 2000 valuations. The basis for reporting will be determined by the provider but must remain consistent from year to year.

PERSONNEL COSTS

Compensation of Owners

Compensation to an owner or related individual must be reasonable and associated with patient care in order to be reimbursable.

Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals

In judging for reasonableness, the Chief Long Term Care Reimbursement may use but is not limited to:

1. Comparison with payments to individuals, other than owners, in comparable facilities or industries.
2. Equating responsibilities and functions performed with a satisfactory salary range.

The allowance for fringe benefits must be consistent with the compensation above.

Compensation of Administrators

An administrator must be a duly licensed person in the State of Rhode Island and be responsible for the overall management and supervision of a facility. Administrators must work on a full time basis and be substantiated by appropriate time records. Assistant Administrators working full time or part time must also be substantiated by time records. Compensation of an administrator is an allowable cost to the extent it does not exceed established maximums governed by bed capacity as shown on the attached schedule, Appendix 'B'. Effective September 1, 1996 Nursing Facilities with a licensed bed compliment of 75 beds or less will be reimbursed based on current allowable costs for the administrator's salary. Said reimbursement will be subject to the ceiling maximums and the provisions as outlined below.

A Nursing Facility with a licensed bed compliment of 75 beds or less that is not fully recognized for reimbursement for the administrator's salary because of the Management Related cost center maximum and whose actual cost is equal to or less than the limitations on Appendix 'B', and is reimbursed for an amount less than the Direct Labor Expenses cost center maximum can receive an amount up to 50 percent of the difference between the Direct Labor cost center maximum and the rate assigned in that cost center to accommodate up to the full administrators salary.

Appendix 'B' will be adjusted annually commencing July 1, 2005 by the amount of percentage change reflected by the Wage and Salary Component of the National Nursing Home Input Price Index as projected by the Centers for Medicare and Medicaid Services for the twelve-month period ending the previous March.

Facilities Operated by Members of a Religious Order

The recognized salary allowance for members of a religious order providing patient care services will be limited to the lower of actual stipend paid on their behalf or the salary equivalent that would be recognized by these Principles of Reimbursement for similar services.

PROFESSIONAL SERVICES

The fees must meet the test of reasonable costs, and must be fully documented by billing which clearly describes the nature of the services rendered.

An example of admissible cost is the fee for legal services in connection with a directive to comply with fire codes regulations. A legal or accounting charge resulting from a buy/sell agreement between related parties is inadmissible. Professional fees

associated with future construction must be deferred and included with the project construction costs.

FRINGE BENEFITS

Fringe benefits such as prepaid health insurance, group life insurance, employees child day care, dental plans, and retirement plans, are allowable costs, providing they are offered to all full-time employees. Similar benefits or partial benefits offered to all permanent part-time employees working at least twenty hours per week will also be recognized. Fringe benefits which advantage officers, owners, or other related individuals in a disproportionate manner will be adjusted to reflect equity of application. Fringe benefits by employee classification must be addressed in the facility's personnel and policy manual in order to be recognized. Benefits other than those stated above must have the prior written approval of the Rate Setting Unit and must be reasonable and necessary for the efficient, effective and economical operation of similar facilities participating in the Rhode Island Medicaid Program.

New fringe benefits provided to full time and permanent part time employees working at least twenty hours per week during a facility's base year will be annualized for prospective calendar years if the cost of the new benefit during the base year was less than a twelve month period. Upgrading and/or substitution of benefits does not qualify for this provision. New fringe benefits must continue through prospective years otherwise a rate reduction will be assigned retroactive to the date benefits were discontinued.

Vacation time and sick leave time are not recognized for reimbursement under the accrual method of accounting and will not be recognized for annualization of new fringe benefits. Vacation time and sick leave time will be recognized as an expense when actually

paid to the employee by the facility.

Profit Sharing Plans: Profit sharing plans must continue in prospective periods at a rate equal to the base period. Failure to fund at a level equal to the amount being reimbursed will result in a recovery of reimbursed costs. This will also result in a reduction to the assigned per diem rate of reimbursement.

OTHER OPERATING COSTS

All operating costs, including nursing, medicine chest, and over-the-counter drug supplies which have been determined as reasonable and acceptable will be allowed after reduction for items not related to patient care.

ACCOUNTING AND AUDITING FEES

Accounting and Auditing services are generally a necessary and proper function in the fiscal operation of long term care facilities. Recognized fees associated with these services must be clearly identified by the employed firm as to responsibility, function of activity, hourly billing rate and time element for each function. The Rate Setting Unit shall determine an appropriate amount for such services to be recognized for reimbursement purposes taking into consideration such factors as; facility employed accountant(s), controller(s), comptroller(s), bookkeeper(s), condition of books and records maintained by the facility, and the necessary direct involvement of the Accounting/Auditing firm.

ROUTINE SERVICES

Expenses pertaining to utilization review of all patients, physical therapy and other remedial therapeutic services will be accepted and considered as routine services for rate calculation.

Expenses pertaining to the services of a Behavior Health Specialist, who is licensed by the State of Rhode Island and is not eligible for direct reimbursement under the Rhode Island Medical Assistance program, will be considered routine services and accepted for rate calculation.

EDUCATIONAL ACTIVITIES

The cost of approved educational activities of full-time employees will be included as an allowable cost provided that such activities are directly related to improving adequate patient care or the administration of the facility. In addition, the activity must be formally organized by a recognized school or organization approved by the State. Educational activities do not cover nurse's aide training and competency evaluation expenditures as these expenditures are not reimbursable through the Medicaid Program.

PHYSICIANS' FEES

Reasonable fees which pertain to utilization review, medical director, employees physical examinations and services required by OBRA-87 are considered allowable costs.

CONFERENCE EXPENSES

Reasonable expenses related to attendance at meetings and conferences may be allowable subject to the following conditions:

- a. The program offered is approved as one which has the purpose of maintaining or improving the quality of patient care or administration within a facility.
- b. The State shall determine whether there is a direct relationship between the job responsibilities of the person in attendance and the subject matter covered.
- c. Attendance to major out-of-state conferences will be limited to two such conferences with not more than one person attending.

MEDICINE CHEST SUPPLIES, TRANSPORTATION AND LAUNDRY EXPENSES

The per diem and interim per diem rates that are established include the reported expenses of nursing and medicine chest supplies, examples of which are, but not limited to, Appendix 'D'; transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patients or their relatives for these services.

INSURANCE

Generally acceptable insurance coverage for business enterprises including the types listed below are reimbursable:

1. Liability Insurance
2. Malpractice Insurance
3. Worker's Compensation
4. Property Insurance

Payment of health and life insurance premiums which provide benefits to an employee or his/her beneficiary are considered fringe benefits and should be claimed as such by the provider. Premiums related to insurance on the lives of officers and key employees which name the provider as beneficiary are not allowable costs. If the individual or his estate are beneficiary, the premiums can be considered compensation to the individual and the cost would be allowable to the extent his/her total compensation is reasonable.

Insurance costs applicable to transportation vehicles will be allowable to the extent of equivalent vehicle units permissible under the principles.

Mortgage insurance premiums are generally not an allowable cost. However, where the principal mortgagee specifically requires that the insurance be obtained as a prerequisite to completing financing arrangements and the insurance agreement stipulates that total proceeds must apply to the mortgage balance, then the premiums shall be reimbursable. The proceeds so applied will be construed as allowed depreciation taken for reimbursement purposes.

START-UP COSTS

"Start-up costs" are defined for the Rhode Island Medicaid Program as those costs incurred for the operation and maintenance of a facility for a period not to exceed six weeks prior to the admission of the first patient. Such costs would include administration and nursing salaries, heat, gas, electricity, insurance, employee training costs (excluding nurse's aide training and competency evaluation expenditures), repairs and maintenance and any other allowable costs incident to the operation of the facility, but not interest, depreciation and real estate and personal property taxes. In as much as start-up costs would relate to services to patients subsequently admitted to the facility, they are considered to be deferred charges and amortization of these charges will be allowed over a period of 60 months.

COST NOT RELATED TO PATIENT CARE

The following are examples of, but not limited to, items which are not recognized for cost reimbursement purposes:

1. personal expenses,

2. items and services for which there is not legal obligation to pay,
3. business expense not related to patient care,
4. physician fees, prescription drugs and medications, as they are covered by means of a separate program,
5. reimbursed expenses,
6. costs of meals sold to visitors and employees,
7. costs of drugs, items and supplies sold to other patients,
8. cost of operation of a gift shop intended to produce a profit. Where expenses cannot be specifically identified the revenue derived will be used to reduce the total operating expenses of the facility.
9. expenses which exceed amounts under the prudent buyer concept,
10. accrued expenses not paid within 90 calendar days after close of the reporting period, except for bankruptcy proceedings, or at time of the audit, examples are but not limited to:
 - a. professional services including attorney and accounting fees,
 - b. unpaid compensation of employees, officers and directors owning stock in a closely-held corporation,
 - c. fringe benefits,
 - d. consultant fees,
 - e. suppliers and vendors,
 - f. trade association dues,Any accrued expenses so disallowed will, however, be recognized

when eventually paid by adjusting the costs of the year in which the expense was incurred.

11. State and Federal income taxes,
12. directory and display advertising or other means of advertising,
13. bad debts,
14. management fees,
15. expenses attributed to anti union activities as specified in H.I.M.-15,
16. excessive purchases of supplies when compared to previous years and years subsequent to base years,
17. employment agency fees/agency contract for purpose of recruitment,
18. costs of beepers,
19. costs of telephone in motor vehicles, and,
20. costs of nurse aide training and competency evaluations.

The inclusion of cost such as those set forth in 1-20 above, which are not related to patient care may constitute a violation of General Laws Section 40-8.2-4, as well as other provisions of State and Federal law and may result in criminal and civil sanctions and possible exclusion from participation in the Medicaid Program.

The State reserves the right to make determinations of admissible and/or inadmissible costs in areas not specifically covered in the principles.

SERVICE AND AFFILIATED ORGANIZATIONS

General

Any company or business entity which provides products and/or services to an

affiliated nursing home or group of homes, where common ownership exists, must be reported to the Rate Setting Unit in order to meet reimbursement requirements.

Reporting Requirements

The report form must be filed for approval. Data required will include but not be limited to:

- a. explanation of the need for such an organization,
- b. ownership interest and legal form of organization,
- c. type of product or services to be rendered,
- d. names of all affiliated facilities to be serviced.

Requests for approval must be filed in advance of the calendar year in which the service and/or affiliated organization provides billable services. This will allow for a determination of whether or not charges from the related service company to the nursing facility will be allowed.

The State requires in addition to the BM-64, the following:

- a. financial statements of the related service company,
- b. tax returns if above statements are not available.

If centralized services such as accounting, purchasing, administration, etc., are involved, complete details regarding the allocation of charges must be provided.

Cost applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Costs include those actually incurred to which may be

added reasonable handling and administrative charges. Profit add-on in the form of markups or by other means is not permitted nor acceptable for reimbursement under the Rhode Island Medical Assistance Program, Title XIX, Medicaid.

HOME OFFICE CHARGES

Long Term Care facilities sometimes operate through a central home office resulting in home office charges. Cost-related expenses may be reimbursable providing that said central home office is physically located within the State of Rhode Island and if they can satisfy the reasonable cost-related concept previously described and if they can demonstrate and document that central management, purchasing and accounting services were uniformly performed for all facilities. Home office cost-related expenses, if the above is satisfied, will be pro-rated to each facility and enterprise for which services are being provided. The central home office must prepare and file with the Rate Setting Unit a cost report annually, in an approved format showing line-cost and allocation to each facility or enterprise. Additionally each enterprise for which services are provided must be fully disclosed.

A central home office established on or after January 1, 1985 must obtain prior written approval from the Rate Setting Unit in order to qualify to have its allocated costs recognized for reimbursement.

In-State Central/Home Office

Cost will be allocated and reimbursed through the Management Related Expenses cost center and All Other Expenses cost center. An In-State Central Office requires maintaining a minimum of three (3) Nursing Care Facilities and must be in operation and approved by July 1, 2004 for consideration for reimbursement.

Out-of-State Central/Home Office

Charges will be recognized to the extent of the lesser of reported reasonable costs of central home office plus costs in Account No.'s 7421-Other Administrative Salaries, No. 7436-Accounting and Auditing Fees or the average allowable amount for facilities of like size and licensure for Account No.'s 7421-Other Administrative Salaries, No 7435-Computerized Payroll and Data Processing Charges and No. 7436-Accounting and Auditing Fees. The acceptable amount will be allowed in the Management Related Expenses cost center.

Changes in Bed Capacity

Facilities in which the bed capacity is either substantially increased or decreased will be re-evaluated insofar as the reimbursement rate, and such change in rate, if at all, will be made retroactive to the date in which such change in bed capacity was authorized by the licensing authority.

Excess Bed Capacity

Per diem rates will be based upon the actual percentage occupancy of the facility's total licensed bed capacity in the base year or 98 percent of the statewide average occupancy rate in the prior calendar year, whichever is greater. For those facilities being licensed for only a portion of their potential bed complement, the 98 percent of the statewide average occupancy rate of the prior calendar year will be based on the available bed days of the portion licensed. However, expenses relating to the physical plant of such facilities such as, but not limited to the following, interest, depreciation and real estate and personal property taxes will be allowed only as they apply to the licensed portion on a per diem predicated upon actual occupancy or 98 percent of the statewide average occupancy rate of the prior calendar year, of total potential bed complement of

the facility, whichever is greater.

Transactions which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact, reductions of previously incurred costs or are added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts and allowances received on purchased goods or services must be netted against the purchase price.

Quality of Care And Cost Incentives

The Department will pay a differential reimbursement rate of \$ 200.00 to providers of service who provide ventilator beds at their facilities. This rate will be in addition to the per diem rate assigned for actual days a resident requires this service, and the rate will only apply to those resident days that are supported by a physician order. This amount will be limited to a maximum of ten (10) beds on a statewide basis and a facility must meet the following criteria:

- The facility must be Medicare-certified.
- The facility must have a minimum of five (5) ventilator beds, and
- The facility must have a licensed Respiratory Therapist on staff or under contract.

The facility must request and receive approval for the differential reimbursement rate in writing from the Rate Setting Unit.

APPENDIX 'A'

BASE YEAR AND AUDIT SCHEDULING

Note: This base year and audit schedule will be utilized for the Management Related and All Other Expenses Cost Centers until September 30, 2005. As of October 1, 2005, this Appendix will no longer be required.

The Schedule for Base Year Calendar Year 1991 and Subsequent Base Years and For Scheduling Base Year Audits Will Be Determined As Follows:

1. Participating Nursing Facilities will be grouped into one level of care category and listed in numerical sequence by license number.
2. During the first audit schedule year and every third year thereafter, the first and each subsequent third listed facility will be scheduled for audit.
3. During the second audit schedule year and every third year thereafter, the second and each subsequent third listed facility will be scheduled for audit.
4. During the third audit schedule year and every third year thereafter, the third and each subsequent third listed facility will be scheduled for audit.
5. Newly constructed facilities and facilities that change ownership will be audited after the completion of six months of operations. Thereafter, these facilities will be scheduled to be audited by adding them to the original listing of facilities by license number sequence.
6. Facilities previously licensed but non-participating that subsequently become participating in the Rhode Island Medicaid Program will be audited after the completion of six months of operation. Thereafter, these facilities will be scheduled to be audited by adding them to the last appearing facility license number at the time of certification.
7. Multiple facilities that are operated, managed and/or controlled by an In-State Central/Home Office or an In-State Management Group will be assigned the same base year and will be scheduled for audit by grouping the facilities. The lowest licensed numbered facility will determine the audit scheduling process by applying provisions 2 through 4 above. Additional facilities serviced by the In-State Central/Home Office will not alter base years and/or audit scheduling of its grouping.

APPENDIX 'B'
ADMINISTRATORS' COMPENSATION

<u>NO. BEDS</u>	Max Salary Allowance
1-75	\$61,745
76	\$63,052
77	\$63,370
78	\$63,685
79	\$64,003
80	\$64,315
81	\$64,636
82	\$64,942
83	\$65,261
84	\$65,574
85	\$66,233
86	\$66,885
87	\$67,541
88	\$68,197
89	\$68,856
90	\$69,513
91	\$70,163
92	\$70,822
93	\$71,477
94	\$72,133
95	\$72,783
96	\$73,442
97	\$74,103
98	\$74,760
99	\$75,410
100	\$76,072
Each Additional Bed	\$ 294

ASSISTANT ADMINISTRATORS WILL BE LIMITED TO THE LOWER OF ACTUAL SALARY PAID OR 75% OF THE ADMINISTRATORS SALARY ALLOWANCE.

APPENDIX 'C'**ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES**

Items of service and supplies which have been identified and defined as routine services and allowable in the per diem rate are listed but not limited to those listed below for Nursing Facilities.

ABD pads	Catheter plugs
A & D ointment	Catheter tray
Adrenal I.M.	Catheters (any size)
Air mattresses	Colostomy bags
Air P.R. mattresses	Composite pads
Airway - oral	Cotton balls
Alcohol	Crutches
Alcohol plasters	"Customized" crutches, canes, and wheelchairs
Alcohol sponges	Decubitus ulcer pads
Antacid suspensions	Deodorants
Antipruritic oil	Disposable underpads
Applicators, cotton tipped	Donuts
Applicators, swab-eez	Douche bags
Aquamatic K pads (water-heated pad)	Drain tubing
Arm slings	Drainage bags
Asepto syringes	Drainage sets
Adhesive tape	Drainage tubes
Baby powder	Dressing tray
Bandages	Dressings (all)
Bandages - elastic or cohesive	Drugs, nonlegend
Band-aids	Drugs, stock; excluding insulin
Basins	
Bed frame equipment (for certain immobilized bed patients)	Enema can
Bed rails	Enema-Fleets
Bedpan, fracture	Enema-retention
Bedpan, regular	Enema soap
Bedside tissues	Enema supplies
Benzoin, aerosol	Enema unit
Bibs	Enemas
Bottle, specimen	Eye pads
Canes	Feeding tubes
Cannula-nasal	Female urinal
Cascara (1 oz.)	Flotation mattress
Catheter, indwelling	Flotation pads and/or turning frames

ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES
(Cont'd)

Folding foot cradle	Medicine dropper
Gastric feeding unit	Methiolate aerosol
Gauze sponges	Milk of magnesia
Gloves, unsterile and sterile	Mineral oil
Gowns, hospital	Mouthwashes
Green soap	Nasal cannula
Hand, feeding	Nasal catheter
Heat cradle	Nasal gastric tubes
Heating pads	Nasal tube feeding
Heel protector	Needles (various sizes)
Hot pack machine	Needles-hypodermic-scalp, vein
Ice bags	Non-allergic tape
Incontinency care	Nursing services (all) regardless of level, including the administration of oxygen and restor. nursing care
Incontinency pads and pants	Nrsng suppl./dressings (other than items of prsnl comfrt/ cosmetics)
Infusion arm boards	Ointment (non-prescription), skin
Inhalation therapy supplies	Overhead trapeze equipment
Aerosol Inhalators, self contained	Oxygen equipment (such as IPPB machines and oxygen tents)
Aerosol (other types)	Oxygen mask
Nasal catheter insertion and tube	Oxygen tank for emergencies
Nebulizer and replacement kit	Pads
Steam vaporizer	Peroxide
Intermittent positive pressure breathing machines (I.P.P.B.)	Pharmaceuticals, non-prescription
Invalid ring	Pitcher
Irrigation bulbs	Plastic bib
Irrigation trays	Pumps (aspiration and suction)
I.V. trays	Restraints
Jelly-lubricating	Room and Board
Keolin and pectin solution	Sand bags
Linens, extra	Scalpel
Lotion, soap and oil	Sheepskin
Male urinal	Special diets
Massages (by nurses)	Specimen cups
Medical social services	

ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES
(Cont'd)

Sponges
Sterile pads
Stomach tubes
Suction catheter
Suction machines
Suction tube
Suppositories
Surgical dressings (including sterile sponges)
Surgical pads
Surgical tape
Suture removal kit
Suture trays
Syringes (all sizes)
Syringes, disposable

Tape for laboratory tests
Tape (non-allergic or butterfly)
Testing sets and refills
Tongue depressors
Tracheostomy sponges
Tray service
Tubing - I.V. trays
Blood infusion set
I.V. tubing

Underpads
Urinary drainage tubs
 Urinary tube and bottle
Urological solutions

Walkers
Water pitchers
Wheelchairs

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM Appendix 'D'

**ACCOUNT
NUMBER**

INCOME

<u>ACCOUNT NUMBER</u>	<u>GROSS INCOME</u>
0300	
0300A	Room and Board - Private-Paying Patients
0300B	Room and Board - Federal Medicare Patients
0300C	Room and Board - State Medicaid Patients
0300D	Room and Board - Veteran Patients
0300E	Room and Board - Blue Cross Patients
0300F	Room and Board - Employees
0300G	Retrospective Adjustment
0301	Sale of Drugs and Supplies
0302	Laboratory Fee Income
0303A	Physical Therapy - Federal Medicare
0303B	Physical Therapy - Private-Paying Patients
0303C	Physical Therapy - Other Patients
0303D	Other Therapeutic Services - Federal Medicare
0303E	Other Therapeutic Services - Private Patients
0303F	Other Therapeutic Services - Other Patients
0304	Utilization Review - Medicare
0305	Laundry Income
0306	Guest and Employee Meals
0307	Vending Machine Income
0308	Income from Empty Beds
0309	Rent
0310	Interest Income
0311	Ancillary Service Income
0312	Meals on Wheels Program
0313	Day Care Program
0314	Other Income (Specify)
0315	Nurse's Aide Training/Competency Evaluation

CHART OF ACCOUNTS WITH EXPLANATION IN SUMMARY FORM Appendix 'D'

(cont'd)

**ACCOUNT
NUMBER****PASS THROUGH ITEMS****EXPENSES**

1451	Real Estate Taxes	Taxes on Real Est./property owned by facility
1451A	Personal Property Taxes	
1451B	Fire Tax	
2512	Fuel	
2513	Gas	
2514	Electricity	
5442	Insurance	Premiums for all institutional insurance
8470	Health Care Provider Assessment	

OTHER PROPERTY RELATED (FAIR RENTAL VALUE)

3452	Interest	Interest on mortgages, loans or notes payable including working capital loans
3453	Rent/Lease	Rent on property leased by facility
3453A	Lease of Equipment	Lease payments
3454	Amortization of Leasehold Improvements	Pro rata share of costs of changes made on bldg leased for business
3455	Building Depreciation	Annual share of estimated depreciation on building
3455A	Building Improvements Depreciation	
3457	Equipment Depreciation	Furniture, fixtures and equipment
3466	Motor Vehicles Depreciation	Cars, trucks, etc.

CHART OF ACCOUNTS WITH EXPLANATION IN SUMMARY FORM Appendix 'D'

ACCOUNT
NUMBER

(cont'd)

DIRECT LABOR

4431	Health Care Plan - Employer's Share	Employer's share of health insurance coverage		
4432	Other Employee Fringe Ben.			
4440	Payroll Taxes	Employer's share of social security taxes and of Federal and State Unemployment & Disability Insurance		
4442A	Insurance-Workers' Compensation			
4511	Maintenance Salaries	Engineers, heating plant employees, watchman, outside maintenance		
4521	Salaries	Dieticians, chefs, cooks, dishwashers, helpers		
4524	Purchased Dietary Services	Outside services		
4531	Laundry Salaries	Laundryman or woman, ironers, seamstress		
4538	Purchased Services	Expenses for outside commercial laundry services, linen hire		
4541	Housekeeping Salaries	Housekeepers, maids, porters		
4548	Housekeeping Purchased Services			
4600	Director of Nurses			
4601	Salaries - R.N.			
4611	Salaries - L.P.N.			
4615A	Physical Therapist - Medicare	Title XVIII-Medicare		
4615B	Physical Therapist - Medicaid	Title XIX-Medicaid		
4615C	Physical Therapist - Private-Paying	Private-Paying patients		
4615D	Physical Therapist - Medicaid other States			
4621	Salaries - Aides & Others	Unlicensed Practical Nurses, Nurses' Aides, Attendant Orderlies		
4622A	Purchased Services of R.N.'s			
4622B	Purchased Services of LPN's			
4622C	Purchased Services of N.A.'s			
4715A	Other Therapeutic Services/Medicare	Salary or purchased services		
4715B	Other Therapeutic Services/RI Medicaid	Salary or purchased services		
4715C	Other Therapeutic Services/Private/Other	Salary or purchased services		
4728A	Other Labor-Salaries, Fees			
			6415	Medical Director Salary/Fee6711 Physician's Salaries/Fees
6713	Social Worker Salary/Fee			

54

6751

Recreational Activity Salaries/Fee

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM Appendix 'D' (cont'd)

ACCOUNT
NUMBER

ALL OTHER EXPENSES

		5425	Office Supplies & Printing
		Stationary, postage, printing, subscriptions & all supplies	
5426	Communications	Telephone, telegraph	
5427	Travel-Motor Vehicle	Cost of operating automobile in connection with administrative duties	
5428	Conventions, Meetings	Registrations, travel and other	
5428A	Education & Seminars	Registrations, travel and other	
5429	Advertising & Public Relations	Advertisements, brochures and all promotional expenses	
5429A	Advertising - Help Wanted	Advertisements for Aides, Nurses, etc.	
5430	Licenses & Dues	Institutional license fees, personal & Institutional membership dues, trade publications, etc.	
5433	Home Office/Central Office	Portion other than labor and payroll-related expenses	
5443	State Franchise Taxes	Corporation or Owners State Tax	
			5449
			Miscellaneous
5515	Water & Sewerage		
5516	Maintenance Supplies	Ladders, lumber, paint, working tools	
5518	Maintenance Purchased Services and Repairs	Contract fees for repairs and services, window washing, cleaning floors, etc.	
5529	detergents used in	Dietary Supplies	Replacement dishes, kitchen utensils, soap and kitchen
5532	Linens & Bedding Supplies	Sheets, mattresses, pillows, towels, wash cloths (replacement only)	
5539	Laundry Supplies	Laundry soap, bleaches, starch	
5549	Housekeeping Supplies	Brooms, brushes, insecticides, polish, soap	
5629	Nursing Supplies	Adhesive, dressings, gauze, thermometers, alcohol, powder, and other Medical Supplies as IV & Sc bottle needles & syringes	
5629A	Medicare		
5629B	RI Medicaid		

56

5629C	-Private Pay & Other
5629D	-Medicaid Other States
5629E	-House

5724	Pharmacy Supplies	Over-the-counter medicines & drugs such as aspirin, vitamins, etc.
5724A	-Medicare	
5724B	-RI Medicaid	

CHART OF ACCOUNTS WITH EXPLANATION IN SUMMARY FORM Appendix 'D'

(cont'd)

ACCOUNT
NUMBER

5724C	-Private Pay & Other
5724D	-Medicaid Other States
5724E	-House

5728 **Other Expenses**
Other supplies not reported elsewhere-specify

5758	Recreational Supplies	Ceramics, handicrafts, movies, leather
5759	Other	

MANAGEMENT RELATED

7411	Administrator (Other than officers/owners)	Person responsible for admin. (no officers/owners)
7412	Officers/Owners Salaries	Compensation paid to officer/owner of the facility
7421	Other Administrative Salaries	Accounting and clerical personnel
7431	Health Care Plan (Employer's Share)	
7432	Other Employee Fringe Benefits	

7433 **Home Office/Central Services**

Home off., ctl. mgt portion attributable to labor and payroll expenses

7435	Computerized Payroll & Data Processing Charges
7436	Accounting and Auditing Fees
7437	Legal Services
7440	Payroll Taxes

7442A	Insurance (Worker's Compensation)
7444A	Utilization Review Medicaid Title XIX
7449A	Miscellaneous Management Related
7523	Consultant Fees - Dietary
7712	Pharmacist Salary or Fees

Appendix 'E'

Rhode Island Department of Human Services
Means Historical Cost Indexes

				Rate of Return	9.00%	
				Capital Cost	66,000	
				Depreciation Rate	1.50%	
01-Oct	Actual Historical Cost Index	Trend Line	% Change		132.99732	
2003					66,000	
2002	1 129.4	129.4	2.78%	61,782.45	64,214.83	
2001	2 125.9	125.9	3.37%	59,768.26	62,477.95	
2000	3 121.8	121.8	3.13%	57,954.29	60,443.32	
1999	4 118.1	118.1	2.07%	56,778.97	58,607.20	
1998	5 115.7	115.7	2.30%	55,502.41	57,416.19	
1997	6 113.1	113.1	2.17%	54,323.59	56,125.94	
1996	7 110.7	110.7	2.41%	53,045.20	54,934.94	
1995	8 108.1	108.1	3.25%	51,375.50	53,644.69	
1994	9 104.7	104.7	2.35%	50,195.90	51,957.44	
1993	10 102.3	2.43 102.3	2.40%	49,019.43	50,766.44	
1992	11 99.9	99.9	2.46%	47,842.50	49,575.44	
1991	12 97.5	97.5	2.63%	46,616.49	48,384.43	
1990	13 95.0	95.0	2.59%	45,439.60	47,143.81	
1989	14 92.6	2.44 92.6	2.66%	44,262.22	45,952.81	
1988	15 90.2	90.2	2.73%	43,085.97	44,761.80	
1987	16 87.8	87.8	2.81%	41,908.35	43,570.80	
1986	17 85.4	85.4	3.14%	40,632.49	42,379.80	
1985	18 82.8	82.8	4.55%	38,864.17	41,089.55	
1984	19 79.2	3.6 79.2	4.76%	37,098.29	39,303.05	
1983	20 75.6	75.6	5.00%	35,331.70	37,516.55	
1982	21 72	72.0	5.26%	33,566.12	35,730.04	
1981	22 68.4	68.4	5.56%	31,798.14	33,943.54	
1980	23 64.8	64.8 64.8	6.40%	29,885.47	32,157.04	
1979	24 60.9	3.9 60.9	6.84%	27,972.17	30,221.66	
1978	25 57.0	57.0	7.34%	26,059.41	28,286.28	
1977	26 53.1	53.1	7.93%	24,144.73	26,350.91	
1976	27 49.2	49.2	8.85%	22,181.65	24,415.53	
1975	28 45.2	45.3 45.2	7.36%	20,661.00	22,430.53	
1974	29 42.1	3.1 42.1	7.95%	19,139.42	20,892.15	
1973	30 39.0	39.0	8.64%	17,617.29	19,353.77	
1972	31 35.9	35.9	9.45%	16,096.20	17,815.40	
1971	32 32.8	32.8	10.81%	14,525.95	16,277.02	
1970	33 29.6	29.6	5.34%	13,789.59	14,689.02	
1969	34 28.1	1.5 28.1	5.64%	13,053.38	13,944.64	
1968	35 26.6	26.6	5.98%	12,316.83	13,200.27	
1967	36 25.1	25.1	6.36%	11,580.32	12,455.89	
1966	37 23.6	23.6	7.76%	10,746.40	11,711.51	
1965	38 21.9	22.1 21.9	1.86%	10,550.17	10,867.89	
1964	39 21.5	0.4 21.5	1.90%	10,353.45	10,669.39	
1963	40 21.1	21.1	1.93%	10,157.41	10,470.89	
1962	41 20.7	20.7	1.97%	9,961.17	10,272.39	
1961	42 20.3	20.3	3.05%	9,666.35	10,073.89	
1960	43 19.7	19.9 19.7	3.14%	9,372.07	9,776.14	
1959	44 19.1	0.6 19.1	3.24%	9,077.94	9,478.39	
1958	45 18.5	18.5	3.35%	8,783.69	9,180.64	
1957	46 17.9	17.9	3.47%	8,489.12	8,882.89	
1956	47 17.3	17.3	2.37%	8,292.59	8,585.14	
1955	48 16.9	16.7 16.9	3.68%	7,998.25	8,386.64	
1954	49 16.3	0.6 16.3	3.82%	7,703.96	8,088.88	

1953	50	15.7		15.7	3.97%	7,409.79	7,791.13
1952	51	15.1		15.1	4.14%	7,115.22	7,493.38
1951	52	14.5		14.5	3.57%	6,869.96	7,195.63
1950	53	14	13.9	14.0	7.69%	6,379.39	6,947.51
1949	54	13.0	1.0	13.0	8.33%	5,888.85	6,451.26
1948	55	12.0		12.0	9.09%	5,398.16	5,955.01
1947	56	11.0		11.0	10.00%	4,907.42	5,458.76
1946	57	10.0		10.0	9.89%	4,465.76	4,962.51
1945	58	9.1		9.1	4.60%	4,269.37	4,515.88
1944	59	8.7	0.4	8.7	4.82%	4,073.05	4,317.38
1943	60	8.3		8.3	5.06%	3,876.88	4,118.88
1942	61	7.9		7.9	5.33%	3,680.70	3,920.38
1941	62	7.5		7.5	7.14%	3,435.41	3,721.88
1940	63	7	7.1	7.0			3,473.75

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HUMAN SERVICES

THE AIME J. FORAND BUILDING

600 NEW LONDON AVENUE

CRANSTON, RI 02920

PRINCIPLES OF REIMBURSEMENT

FOR

INTERMEDIATE CARE FACILITIES – MENTALLY RETARDED

EFFECTIVE OCTOBER 1, 2003

PRINCIPLES OF REIMBURSEMENT

MEDICAID
PRINCIPLES OF REIMBURSEMENT
TABLE OF CONTENTS

	<u>PAGE</u>
APPLICABLE STATE AND FEDERAL LAWS	1
RECORDS RETENTION	1
GENERAL:	
Reporting	
Reasonable Costs	3
Upper Limits	4
Annual Cost Report	4
Admission Policy	4
Method of Payment to ICF-MR Facilities	5
Personal Clothing: ICF-MR	5
Method for Determining Individual Rates	6
Payments	8
Appeals Process	6
Recordkeeping	8
Audit of Provider Costs	8

PRINCIPLES OF REIMBURSEMENT

APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966, under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97 which was enacted by the Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40, Chapter 8 of the Rhode Island General Laws, 1956, as amended.

The Power of the Director

Rhode Island General Laws 40-8-13 provides that the Director of the Department of Human Services, shall make and promulgate rules, regulations, and fee schedules, for the proper administration of the Medical Assistance Program, and to make the Department's State Plan for Medical Assistance conform to the provisions of the Federal Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4 and 40-8.2-7 of the Rhode Island General Laws and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Chapter 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

Records Retention as Provided For By the Statute of Limitations (12-12-17)

Each provider of ICF-MR services participating in the Title XIX Medical Assistance Program in accordance with the provisions of these Principles of Reimbursement will maintain within the

State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual Cost Report. However, original invoices, canceled checks, contracts, minutes of board of directors meetings and any other material used in the preparation of the annual cost report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with the State Agency as required by the Statute of Limitation. Each provider will make available upon request such records and all other pertinent records to representatives of the State Agency, representatives of the Federal Department of Health and Human Services, and the State's Medicaid Fraud Unit within the State's Attorney General Office.

The State Agency will maintain all cost reports submitted by providers and all audit reports prepared by the Agency for at least ten (10) years after the month in which the cost report was filed by the provider or at least ten (10) years after the month in which the audit was conducted.

These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the State's Administrative Procedures Act.

The State will pay to participating providers of ICF-MR services who furnish services in accordance with the requirements of the Principles of Reimbursement the amount determined for services furnished by the provider under said Principles of Reimbursement.

If an overpayment to a participating provider of ICF-MR services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by Section 40-8.2-22 of the Rhode Island General Laws.

GENERAL

Reporting

Reasonable Costs

The provision of ICF-MR Services to Medicaid recipients is provided only to those individuals who are eligible for these services in accordance with Medicaid regulations relating to resource and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. Reimbursement rates will be reasonable and adequate to meet costs that must be incurred by economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those costs of an individual facilities for items, goods and services which, when compared, will not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare – Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public for such services. The Upper Payment Limit is based on reasonable cost as is our payment.

Annual Cost Report

All facilities, with the exception of Public ICF-MR's, must file an annual cost report on a calendar year basis. The report format is determined by the Center for Adult Health's Rate Setting Unit and must be filed on or before March 31 following the close of the year.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit a cost report on time without written authorization extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis until said BM-64 is submitted or facility is terminated from the program for failure to file a cost report within six months from the close of the reporting year.

A final cost report must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

Admission Policy

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws,

patients shall have the right to remain in a facility after the depletion of private funds.

METHOD OF PAYMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED AND TO INTERMEDIATE CARE FACILITY PUBLIC INSTITUTION FOR THE RETARDED

The Principles of Reimbursement for Intermediate Care Facilities for the Mentally Retarded will be HIM-15, Federal Medicare, with the exclusion of the provision for a return on net equity.

Personal Clothing: ICF-MR

Rates of reimbursement assigned to Intermediate Care Facilities for the Mentally Retarded will include an amount not to exceed one dollar (\$1.00) per day per client for the cost of purchasing personal clothing. This one dollar (\$1.00) per diem allowance for clothing is not to be commingled with the facility's operating funds, personal needs funds, resident earnings or any other funds. A separate account is to be maintained by the facility which will account for all client personal clothing revenue and expenditures. The client personal clothing account will be summarized on individual client ledger cards showing name, dates of deposits, withdrawals and balance. Each withdrawal is to be substantiated by an itemized paid bill identifying the client name, articles of clothing purchased, and the date of purchase.

The client ledger cards for personal clothing, when totaled, will agree to the balance of the established separate personal clothing account. This reconciliation must be done on at least a monthly basis.

The recognized personal clothing expenditure for each client will not exceed the amount of one dollar (\$1.00) per day. The facility will be responsible in monitoring the expenditures to ensure that this limitation is not exceeded.

Therefore, the clothing fund account for a resident must not have a negative balance.

Clothing funds are considered to be on the accrual basis of accounting.

When a client dies, is discharged to a non-ICF-MR facility (waiver, apartment program, etc.), is discharged to a ICF-MR which is not part of the same corporation, or is discharged to the community, it will be necessary for the facility to transmit to the Department of Human Services, Rate Setting Unit, any unexpended funds from that resident's Personal Clothing Account within a period of twenty days.

If a facility is decertified from the ICF-MR Program, or voluntarily withdraws from the Program, the entire amount from each residents personal clothing account must be remitted to the Department of Human Services, Rate Setting Unit within twenty days.

As of January 31 of each calendar year, it will be necessary for the facility to remit to the Department of Human Services any unexpected or unencumbered funds in individual clothing accounts in excess of \$90.00 recorded as of midnight on December 31 of the previous year.

Audits will be conducted on these accounts periodically in order to ensure compliance with the above-specified requirement.

Method of Determining Individual Rates

Each facility will be assigned an interim rate either based on an approval budget request or the previous years cost report pending submission of the annual cost report to determine the retroactive settlement rate. Rates based on a proposed budget or cost reports are determined by the Department's Rate Setting Unit. Reimbursement is based on a retrospective system.

Appeals Process

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit results or rate

assignments file a written request for a review conference to be conducted by the Associate Director, Division of Health Care, Quality, Financing and Purchasing or other designee assigned by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The Associate Director or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associate Director or the designee appointed by the Director of the Department of Human Services will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

Transactions Which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact reductions of previously incurred costs or are added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts and allowances received on purchased goods or services must be netted against the purchase price.

Medicine Chest Supplies, Transportation and Laundry Expenses

The per diem and interim per diem rates that are established include the reported expenses of nursing and medicine chest supplies, transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories and

hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patient or their relatives for these services.

Payments

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made, the date of admission is counted; however, the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under the State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is prohibited.

Recordkeeping

Adequacy of Cost Information

Providers of ICF-MR services under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledger, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.) All records must be physically maintained within the State of Rhode Island.

Audit of Provider Costs

In accordance with 45 CFR-250.30p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs and final cost reports. All costs of new construction will be audited by the State as herein described. Final cost reports submitted by a provider due to change in ownership, closing of a facility or discontinuance in the Medicaid Program shall be subject to audit within a reasonable time after such change has taken place.

Services and affiliated organizations where common ownerships exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups (see page for definition of service and affiliated organizations).

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid Principles of Reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.