Rhode Island

Executive Office of Health and Human Services

PRINCIPLES OF REIMBURSEMENT
FOR
NURSING FACILITIES

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PRINCIPLES OF REIMBURSEMENT
TABLE OF CONTENTS

	Page
APPLICABLE FEDERAL AND STATE LAWS	**1**
Legal Basis for Program	1
The Powers of the Director	1
Penalties for Misrepresentation or Fraudulent Acts	1
INTRODUCTION	**2**
RECORDS RETENTION	**3**
GENERAL	**5**
Reporting	5
Reasonable Costs	5
Upper Limits	6
Annual Cost Report BM-64	7
Admission Policy	8
Participation	8
Method for Determining Cost Center Ceilings	9
Method for Determining Individual Prospective Rates	10
Temporary Rates for Newly Constructed Facilities	13
Appeals Process	14
Appeal Requests for Prospective Rate Increments	15
Enterprise Zone	17
Special Prospective Rate Appeal	18
Payments	19
Record keeping	20
Adequacy of Cost Information	20
Census Data	20
Audit of Provider Costs	20
OPERATING COSTS	**22**
Property Payment – Fair Rental Value System	22
Transportation Vehicles	28
Real Estate and Personal Property Taxes	29
PERSONNEL COSTS	**30**
Compensation of Owners	30
Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals	30
Compensation of Administrators	30

Facilities Operated by Members of a Religious Order 31

PROFESSIONAL SERVICES 32
Fringe Benefits 32
Other Operating Costs 33
Accounting and Auditing Fees 33
Routine Services 34
Educational Activities 34
Physicians' Fees 34
Conference Expenses 34
Medicine Chest Supplies, Transportation, and
Laundry Expenses 35
Insurance 35
Start-up Costs 36

COST NOT RELATED TO PATIENT CARE 37

SERVICE AND AFFILIATED ORGANIZATIONS 40
General 40
Reporting Requirements 40

HOME OFFICE CHARGES 42
In-State Central/Home Office 42
Out-of-State Central/Home Office 42
Changes in Bed Capacity 43
Excess Bed Capacity 43
Transactions Which Reduce Reported Cost of Patient Care 44
Refunds, Discounts, and Allowances 44
Quality of Care and Cost Incentives 44
Energy Conservation Retention Credit 45

APPENDIX
A Administrator's Compensation 46
B. Routine Services and Supplies 47
C. Chart of Accounts 49
D. Historical Cost Indexes 54

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 Chapter 42-7 .2-2(b} provides that the Secretary of the Executive Office of Health and 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.

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 or appeal period; will not be subject to a retrospective adjustment to reflect increases or decreases in actual costs.

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.

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 Executive Office of Health and 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 costs 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 event may payment exceed the upper payment limit as stated in 42 CFR 447.272. Conformance with the Upper Payment Limit has been determined using the "Conservative Approach" methodology. The Conservative Approach utilizes the lowest RUG price and Title XIX days. The result of multiplying the RUG price and Title XIX days has been compared with the Title XIX payments made by the State.

For each month, the State identified the Title XIX days relating to claims for each facility. Title XIX days, for each month for each facility, were multiplied by the lowest RUG price PA-1 per the Federal Register. The State also identified the Title XIX dollar amounts paid to each facility relating to claims for each month. In addition, the dollar amount paid for prescription drugs for residents in nursing facilities was separately determined. The dollar amount paid for prescription drugs was added to the dollar amount resulting from the calculation of the days multiplied by the lowest RUG price.

The State compared the total dollar amount paid for Title XIX days using the lowest RUG price with the total dollar amount paid by the State including the amounts paid for prescription drugs. It

should be noted that the payment for drugs for Title XIX residents, that has been included in the calculations to arrive at total payments, is not paid to the nursing facility. However, because this methodology is based on a Conservative Approach, the State included the dollar amount paid for prescription drugs to capture all applicable payments for Title XIX nursing facility residents.

The Upper Payment Limit as calculated for Title XIX days using the lowest RUG is greater than the total dollar amount paid by the State, including payments for prescription drugs, for Title XIX.

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 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 (6) 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 twenty (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 (6) months from the close of the reporting year.

A final BM-64 must be filed within ninety (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

Facilities and at least twenty-five (25) percent 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 Secretary of the Executive Office of Health and 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.

The Medicaid Director must approve an increase in the licensed bed capacity, new beds, or beds out of service brought back into service, for participation and payment in Title XIX Medicaid.

METHOD FOR DETERMINING COST CENTER CEILINGS

1. Pass Through Items: The Pass Through Cost Center is such that a ceiling maximum is not calculated. This cost center grouping will include allowable costs reported in all account numbers as listed in Appendix 'C' – Chart of Accounts. 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 recognized for reimbursement through an add-on to the per diem rate equal to the Health Care Provider Assessment as compounded.
2. Direct Labor: This cost center grouping will include allowable costs in all account numbers as listed in Appendix 'C' – Chart of Accounts. Costs will be allowed up to a ceiling maximum of one hundred ten (110) percent of the median of the costs of all facilities arrayed.

   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, one hundred ten (110) percent 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, with the exception of: October 1, 2006 which will be applied February 1, 2007; October 1, 2007 which is limited to 1.1%; October 1,

2008 which will be applied April 1, 2009; and October 1, 2011 which is limited to 0%. Costs in the Direct Labor Cost Center will be arrayed every three years.

3. Fair Rental Value System: The Fair Rental Value System is such that a ceiling maximum is not calculated.

4. Other Operating Cost Center: This cost center grouping will include allowable costs in all account numbers as listed in Appendix 'C' – Chart of Accounts.

BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for Hospital Based Skilled Nursing Facilities) will be grouped and allowable cost center per diems will be arrayed in descending order in the Other Operating Cost Center. The appropriate percentile, one hundred five (105) percent of the median for the Other Operating Cost Center, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Executive Office of Health and Human Services effective July 1, 2003 and then each subsequent October 1st with the exception of: October 1, 2006 which will be applied February 1, 2007; October 1, 2007 which is limited to 1.1%; October 1, 2008 which will be applied April 1, 2009; and October 1, 2011 which is limited to 0%. Costs in the Other Operating Cost Center will be arrayed every three years.

Method of Determining Individual Prospective Rates

1. Individual facility cost center rates (excluding the Fair Rental Value System Cost Center) will be adjusted annually by the amount of percentage change in the National Nursing Home Input Price Index (NHIPI), or comparable 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. The comparable index will be the Skilled Nursing Facility Total Market Basket index as published by Global Insights for the same period if the NHIPI is not available.

2. 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, with the exception of: October 1, 2006 which will be applied February 1, 2007; October 1, 2007 which is limited to 1.1%; and October 1, 2011 which is limited to 0$. The interim prospective per diem rate will be adjusted, if necessary, through results of a desk/field audit of base year costs for the Direct Labor and Pass Through Items Cost Center.

3. Effective October 1, 2005 for the Other Operating Cost Center, each facility will be assigned an interim prospective rate utilizing the facility's base year 2004 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 this cost center, based on the immediate prior calendar year cost report, increased by the recognized percentage change applied as of July 1, with the exception of: October 1, 2006 which will be applied February 1, 2007;October 1, 2007 which is limited to 1.1%; and October 1, 2011 which is limited to 0%. The interim prospective rate will be adjusted, if necessary, through results of a desk/field audit of base year costs for the Other Operating Cost Center.

4. For the period April 15, 2009 to June 30, 2009, the Department of Human Services has been authorized to reduce the per diem room and board rate calculated in accordance with the Principles of Reimbursement, paid to the nursing facilities certified to participate in the Title XIX Medicaid program for services rendered to Medicaid-eligible residents, by five percent (5%). This reduction is deemed to be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. section 1396a (a) (13).

5. Effective February 1, 2010, the Direct Care component of the prospective per diem rate is subject to adjustment based on the acuity of the Medicaid residents of the nursing facility.

   a. Facility acuity is determined in a three-step process

      i. Each Medicaid resident is assigned to a Resource Utilization Group (RUG) using the 34-RUG model and the index maximizing option. Categorization reflects the nursing facility population on selected census dates twice a year.

      ii. Each RUG has a relative weight specific to Rhode Island. For a specific RUG, the relative weight equals the nursing minutes per day (from the CMS time study) times the weighted average cost of nursing minutes from Rhode

Island nursing facility cost reports. RUG weights are centered to achieve a Medicaid statewide average acuity of 1.00 periodically.

iii. A facility's acuity equals the simple average of the RUG relative weights for its Medicaid residents on the census date.

b. For each facility, the prospective per diem rate will be adjusted to account for the difference between the facility's cost of Direct Care and the statewide Direct Care component times the facility acuity. For example, if the statewide Direct Care cost equals $80 and a facility has acuity of 1.1 and Direct Care cost of $ 81 then the facility's acuity adjustment would be $7 or (($80 X 1.1)- $81).

i. The statewide Direct Care component reflects the most recently submitted cost reports.

ii. Direct Care cost per day is based on the reported cost of RNs, LPNs and aides, plus an allocation of payroll taxes and fringe benefit costs.

iii. The statewide average cost of a day of nursing care is a weighted average Direct Care cost, based on the number of bed days paid by Medicaid to each facility for the year ending in the census date.

c. DHS may apply transitional limits on the maximum acuity adjustment. Transitional limits will assure that no facility's rate is impacted beyond specified percentages.

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. Facilities that change

ownership may be allowed a temporary reimbursement rate in the Direct Labor Cost Center category only pending review of sufficient cost data. Upon completion of a six (6) 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 (6) 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 (6) months 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

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 fifteen (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 Medicaid Director, or other designee assigned by the Secretary of the Executive Office of Health and Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Medicaid Director or designee shall schedule a review conference within fifteen (15) days of receipt of said request. As a result of the review conference, the Medicaid Director or designee may modify the audit adjustments and the rate of reimbursement. The Medicaid Director or designee

shall provide the provider with a written decision within thirty (30) days from the date of the review conference.

Appeals beyond the Medicaid 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 fifteen (15) days of the decision noted in the paragraph above.

APPEAL REQUESTS FOR PROSPECTIVE RATE INCREMENTS

The Executive Office of Health and Human Services may 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 those instances where the appeal request is not in reference to the Fair Rental Value System rate, the Fair Rental Value System rate will not be considered in the aggregate rate calculation. In order to qualify for the rate increment, demonstrated increased cost must be the result of:

1. Demonstrated errors made during the rate determination process.
2. 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.
3. (a) 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.

   (b) Increased energy costs which the facility can demonstrate are a result of the facility

having expended funds for heating, lighting, hot water, and similar costs associated with the consumption of energy provided by public utilities.

4. Significant increases in workers' compensation and/or health insurance premiums which cannot be accommodated within the nursing facility's assigned aggregate per diem rate, if cost justified, provided that the assigned rate in the applicable cost center(s) does not exceed two percent (2%) of the cost center ceiling.

5. 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. Provided however that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

All requests for rate increments shall be limited to one request per nursing facility for the factors set forth in sections 2 & 3 provided additional requests involving a per diem increase in excess of one percent of nursing facility's previously assigned aggregate per diem rate shall also be reviewed.

Before a nursing facility shall be permitted to file for a rate_increment, increases in operating costs set forth in sections 2 & 3 must have been incurred for a period of not less than three (3) months in order to establish proof of the increase.

Rate adjustments granted as a result of a request filed within one hundred twenty (120) days after the costs were first incurred shall be made effective retroactively to the date the costs were actually incurred; provided, further, any adjustments granted as a result of requests filed more than one hundred twenty (120) days after the costs were first incurred will be effective on the first day of the

month following the filling of the request.

ENTERPRISE ZONE

A facility may qualify for a rate increment adjustment in accordance with this section:

1. The facility is located in a federally designated Enterprise Community; and
2. The facility is incurring allowable costs in one or more cost centers in excess of the allowable maximum for such cost center(s); and
3. The facility files a written request for a rate increment with the Department which must include the following documentation:
    a. A cost containment and revenue enhancement plan; and
    b. A cost report for the most recently completed six (6) months of operations; and
    c. 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.

SPECIAL PROSPECTIVE RATE APPEAL

Any facility that has been directed by the Department of Health to appoint an independent quality monitor, engage an independent quality consultant or temporary manager and/or develop and implement a plan of correction to address concerns regarding resident care and coincident financial solvency may file for a Special Rate Appeal. The Special Rate Appeal components are as follows:

1. The provider must submit a written request (including a copy of the plan of correction) to the Department of Human Services, Rate Setting Unit.

2. The request must be based on the approved spending plan set forth in the plan of correction and remediation.

3. The provider must submit evidence that the approved spending plan cannot be accommodated by the existing per diem rate.

4. The rate appeal will not be for a period of less than six (6) months.

5. The Department, at its discretion, may provide for subsequent extensions for six (6) month periods for a maximum total period of twenty-four (24) months.

6. The provider must submit a BM-64 Cost Report for each six (6) month appeal period.

7. The Department will recoup any funds not expended during the six (6) month appeal period.

8. In calculating the Special Prospective Rate Appeal, the Department will disregard cost center ceiling maximums for the Direct Labor and Other Operating Cost Centers.

9. Upon conclusion of the six (6) month period (or subsequent extension periods), the per diem rate will revert to what the provider's normal base period rate calculation would be with the exception of the Direct Labor Cost Center. A spending plan for additional necessary staffing only must be submitted to the Rate Setting Unit. Approved additional staffing may result in an increase to the Direct Labor Cost Center per diem from this Cost Centers normal base period rate.

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.

RECORD KEEPING

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 (6) 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. This rate will remain in effect until such time the Fair Rental Value System rate exceeds the facility 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 ten (10) percent 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 thirty-five (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 up to a ceiling of four (4.0) percent.

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 twenty (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 ninety-eight (98) percent 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 patient days provided that such patient days are greater than ninety-eight (98) percent of the statewide average occupancy rate of the prior 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. To qualify as a bed replacement, the cost of the renovation/improvement must be equal to or greater than the cost of constructing one nursing facility bed in the year in which the renovation takes place. 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

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.

b. 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 three (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 (3) 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 'D' 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
6.54	0	0
103.46	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
8	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 one hundred (100) percent nursing facility business use, only the percentage attributable to nursing facility business use will be recognized.

Expenditures for gas, oil, and repairs of transportation vehicles will be allowable to the extent of the number of vehicles permissible under the principles. However, in all cases, the Executive Office of Health and 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 (4) 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 'A.' Administrators Compensation.

Appendix 'A' will be adjusted annually commencing July 1, 2007 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 (12) month

period ending the previous March, with the exception of the Federal fiscal year commencing October 1, 2011 which is limited to 0% and which will be limited to 0% until such time that the Price Index is restored to the cost centers, at which point the applicable Salary Component of the Price Index will apply.

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 (20) 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 (20) 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 (12) month period.

Upgrading and/or substitution of benefits do 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.

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:

1. 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.

2. The State shall determine whether there is a direct relationship between the job responsibilities of the person in attendance and the subject matter covered.

3. 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 'B'; 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.

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 (6) 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 sixty (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 ninety (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:

1. explanation of the need for such an organization,
2. ownership interest and legal form of organization,
3. type of product or services to be rendered,
4. 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:

1. financial statements of the related service company,
2. 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 Other Operating 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 Number's: 7421-Other Administrative Salaries, No. 7435 -

Computerized Payroll and Data Processing Charge, No. 7436-Accounting and Auditing Fees or the average allowable amount for facilities of like size and licensure for Account Number's 7421-Other Administrative Salaries, No 7435-Computerized Payroll and Data Processing Charge and No. 7436-Accounting and Auditing Fees. The acceptable amount will be allowed in the Other Operating 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 ninety-eight (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 ninety-eight (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, Fair Rental Value System, if applicable, 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 ninety-eight (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 thirty (30) beds on a statewide basis and a facility must meet the following criteria:

1. The facility must be Medicare-certified.
2. The facility must have a minimum of five (5) ventilator beds, and
3. The facility must have a licensed Respiratory Therapist on staff or under contract.
4. The facility must request and receive approval for the differential reimbursement rate in writing from the Rate Setting Unit.

ENERGY CONSERVATION RETENTION CREDIT

Every licensed nursing facility participating in the Medicaid medical assistance program that:

1. Expends funds for energy conservation measures and the use of renewable fuels, energy sources, and so called "green" sources of energy that result in a reduction of energy consumption; and
2. Which methods can demonstrate, to the satisfaction of the Department, result in the facility's Pass Through per diem cost being reduced in the next base year in comparison to the immediately preceding base year shall be permitted to retain the difference in the previous per diem and the new per diem for a period of twenty-four (24) months.

Provided that such retained funds shall be utilized by the nursing facility solely for either (1) costs directly associated with employing labor at the facility or (2) to pay down any debt of said nursing facility incurred directly through the purchase of energy saving, conservation and renewable energy or so-called green devices.

Energy conservation measures would include but not be limited to; insulation, lighting projects and retrofits, furnace replacements, HVAC upgrades, weatherproofing, window and door replacements, energy managements systems, etc. Renewable fuels energy sources and green sources of energy would include but not be limited to; wind power, solar power, geothermal, water related power, etc.

Providers must document savings from one calendar year to the next calendar year in similar energy cost categories such as, electricity, fuel, gas, etc. The first documented savings year would be calendar year 2008, as compared to calendar year 2007, which would assign a credit effective October 1, 2009.

APPENDIX 'A'

ADMINISTRATORS' COMPENSATION
January 1, 2008

NO.OFBEDS	Maximum Salary Allowance
1-75	$70,104
76	$71,588
77	$71,948
78	$72,306
79	$72,667
80	$73,022
81	$73,386
82	$73,733
83	$74,096
84	$74,451
85	$75,199
86	$75,939
87	$76,685
88	$77,429
89	$78,178
90	$78,923
91	$79,661
92	$80,409
93	$81,153
94	$81,898
95	$82,636
96	$83,384
97	$84,134
98	$84,881
99	$85,619
100	$86,370
Each Additional Bed	$ 334

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

APPENDIX 'B'

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
A & D ointment
Adhesive tape
Adrenal I.M
Air mattresses
Air P.R. mattresses
Airway - oral
Alcohol
Alcohol plasters
Alcohol sponges
Antacid suspensions
Antipruitic oil
Applicators, cotton tipped
Applicators, swab-eez
Aquamatic K pads (water-heated pad)
Arm slings
Asepto syringes
Baby powder
Bandages
Bandages - elastic or cohesive
Band-aids
Basins
Bed frame equipment (for certain immobilized bed patients)
Bed rails
Bedpan, fracture
Bedpan, regular
Bedside tissues
Benzoin, aerosol
Bibs
Bottle, specimen
Blood infusion set
Canes
Cannula-nasal
Cascara (1 oz.)
Catheter, indwelling
Catheter plugs
Catheter tray
Catheters (any size)
Colostomy bags
Composite pads
Cotton balls
Crutches
"Customized" crutches, canes, and wheelchairs
Decubitus ulcer pads
Deodorants
Disposable underpads
Donuts
Douche bags
Drain tubing
Drainage bags
Drainage sets
Drainage tubes
Dressing tray
Dressings (all)
Drugs, nonlegend
Drugs, stock; excluding insulin
Enema can
Enema-Fleets
Enema-retention
Enema soap
Enema supplies
Enema unit
Enemas
Eye pads
Feeding tubes
Female urinal
Flotation mattress
Flotation pads and/or turning frames
Folding foot cradle
Gastric feeding unit
Gauze sponges
Gloves, unsterile and sterile
Gowns, hospital
Green soap
Hand, feeding
Heat cradle
Heating pads
Heel protector
Hot pack machine
Ice bags
Incontinency care
Incontinency pads and pants
Infusion arm boards
Inhalation therapy supplies
  Aerosol Inhalators, self contained
  Aerosol (other types)
  Nasal catheter insertion and tube
  Nebulizer and replacement kit
  Steam vaporizer

Intermittent positive pressure breathing machines (I.P.P.B.)
Invalid ring
Irrigation bulbs
Irrigation trays
I.V. tubing
I.V. trays
Jelly-lubricating
Keolin and pectin solution
Linens, extra
Lotion, soap and oil
Male urinal
Massages (by nurses)
Medical social services
Medicine dropper
Methiolate aerosol
Milk of magnesia
Mineral oil
Mouthwashes
Nasal cannula
Nasal catheter
Nasal gastric tubes
Nasal tube feeding
Needles (various sizes)
Needles-hypodermic-scalp, vein
Non-allergic tape
Nursing services (all) regardless of level, including the administration of oxygen and restor. nursing care
Nrsng suppl./dressings (other than items of prsnl comfrt/ cosmetics)
Ointment (non-prescription), skin
Overhead trapeze equipment
Oxygen equipment (such as IPPB machines and oxygen tents)
Oxygen mask
Oxygen tank for emergencies
Pads
Peroxide
Pharmaceuticals, non-prescription
Pitcher
Plastic bib
Pumps (apiration and suction)
Restraints
Room and Board
Sand bags
Scalpel
Sheepskin
Special diets
Specimen cups
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
Underpads
Urinary drainage tubs
Urinary tube and bottle
Urological solutions
Walkers
Water pitchers
Wheelchairs

Appendix 'C'

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM

ACCOUNT NUMBER	INCOME
0300	GROSS INCOME
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

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.
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

ACCOUNT NUMBER		
541	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/Fee	
6711	Physician’s Salaries/Fees	
6713	Social Worker Salary/Fee	
6751	Recreational Activity Salaries/Fee	

OTHER OPERATING COST CENTER

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

ACCOUNT NUMBER		
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	Dietary Supplies	Replacement dishes, kitchen utensils, soap and detergents used in 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 Supplies as IV & Sc	Adhesive, dressings, gauze, thermometers, alcohol, powder, and other Medical bottle needles & syringes
5629A	Medicare	
5629B	RI Medicaid	
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	
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	
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	

ACCOUNT NUMBER		
7433	Home Office/Central Services	Home off., ctl. mgt portion attributable to labor and payroll expenses
7435	Computerized Payroll & Data Processing Charge	
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 'D'

Rhode Island Medicaid Agency
Means Historical Cost Indexes

EFFECTIVE JULY 1, 2005 AND SUBSEQUENT

			Prior Year	Current Year	% Change	Amount per bed
Dec2006	Eff. 7/1/2007	5.14%	155.6	163.6	4.0%(Max)	72,906
Dec2005	Eff. 7/1/2006	12.1%	138.8	155.6	4.0%(Max)	70,102
Dec2004	Eff. 7/1/2005	2.13%	135.9	138.8	2.13%	67,406

EFFECTIVE SEPTEMBER 1 ,2004

01-Oct		Actual Historical Cost Index		Trend Line	% Change		132.99732
2003							66,000.00
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

Rhode Island Medicaid Agency

Means Historical Cost Indexes

EFFECTIVE JULY 1, 2005 AND SUBSEQUENT

01-Oct		Actual Historical Cost Index		Trend Line	% Change		
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