a. **Exception To New Bed Rate**. The following situations will not be treated as new beds for reimbursement purposes: (7-1-99)T

b. Any beds converted from nursing facility to assisted living beds may not be reclassified to new nursing facility beds until three (3) years have elapsed from the date the beds were reclassified to assisted living beds. (7-1-99)T

c. Beds which are added as a result of expansion plans which the Department was made aware of in writing prior to July 1, 1999. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning and/or development. Simply the existence of adequate land and/or space will not constitute having expended significant resources for the pruposes of expansion. A written request with adequate supporting documentation for an exception under this provision must be received by the Department no later than December 31, 1999. In no case will beds added subsequent to July 1, 2003 qualify for the exception to the new bed criteria. (7-1-99)T

d. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility may be re-certified as existing beds with the approval of the Department. (7-1-99)T

305. TREATMENT OF NEW FACILITIES.
Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1 to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1 with the existing facilities in accordance with Section 302 of this rule. (7-1-99)T

306. TREATMENT OF A CHANGE IN OWNERSHIP.
New providers resulting from a change in ownership of an existing facility shall receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. (7-1-99)T

307. DISTRESSED FACILITY.
If the Department determines that a facility is experiencing operational, financial, or patient service problems, the Department may to the extent the provider demonstrates to the satisfaction of the Department that a new rate is appropriate, negotiate a reimbursement rate different than the rate then in effect for that facility. (7-1-99)T

308. INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Changes in state and federal laws and regulations may (I) result in additional payment for costs, (ii) impact the cost limit calculation of payment rates, or (iii) require restrospective settlement. (7-1-99)T

01. **Changes Of More Than Fifty Cents Per Patient Day In Costs**. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (7-1-99)T

a The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (7-1-99)T

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (7-1-99)T

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-99)T

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-99)T

03. Future Treatment Of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (7-1-99)T

309. MDS REVIEWS.

The following Minimum Data Set reviews will be conducted: (7-1-99)T

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (7-1-99)T

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (7-1-99)T

310. SPECIAL RATES.

Section 56-117, Idaho Code, provides authority for the Director to pay facilities a special rate for care given to patients who have long term care needs beyond the normal scope of facility services. These patients must have needs which are not adequately reflected in the rates calculated pursuant to the principles set forth in Section 56-102, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (7-1-99)T

01. Determinations. A determination to approve or not approve a special rate will be made on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request will be for an expected condition that will be on-going for a period of greater than two weeks. (7-1-99)T

02. Application. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in Section 56-102, Idaho Code. (7-1-99)T

03. Approval. Approved special rates will become effective on the date the application is received, but no earlier than the first day of the month in which the application for a special rate was received. (7-1-99)T

04. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (7-1-99)T

05. Limitation. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (7-1-99)T

311. PHASE-IN PROVISIONS.

The rates established pursuant to these rules shall be phased in over a three-year period as follows: (7-1-99)T

01. July 1, 1999 Through June 30, 2000. During this period, providers will continue to be reimbursed under the previous retrospective system; however, the Department will also issue by July 1, 1999 and October 1, 1999, "shadow rates" which will inform facilities what their rate would be under the provisions of these rules. (7-1-99)T

02. July 1, 2000 Through December 31, 2000. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of one dollar ($1) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than one dollar ($1) per resident day will have the decrease in their rate limited to the greater of one dollar ($1) per resident day or twenty-five percent (25%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

03. January 1, 2001 Through June 30, 2001. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of two dollars ($2) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than two dollars ($2) per resident day will have the decrease in their rate limited to the greater of two dollars ($2) per resident day or fifty percent (50%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

04. July 1, 2001. Beginning with July 1, 2001, the rates established under the provisions of these rules will be fully implemented with no phase-in. (7-1-99)T

312. (RESERVED)

313. DISPUTES.

01. Administrative Review Requirement. If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the Director, it shall first pursue the administrative review process set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 300, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

02. Legal Challenge. The administrative review process need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision. (12-31-91)

314. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY.

The Director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars ($1000) per violation

in any case in which it finds that the facility, or any partner, officer, director, owner of five percent (5%) or more of the assets of the facility, or managing employee: (12-31-91)

01. Failed Or Refused To Comply. Failed or refused to comply with the requirements of Sections 56- 101 through 56-135, Idaho Code, or the rules established hereunder; or (1-1-82)

02. False Statements. Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or (1-1-82)

03. Refused To Allow Representative. Refused to allow representatives or agents of the Director to inspect all books, records, and files required to be maintained by the provisions of this chapter or to inspect any portion of the facility's premises; or (1-1-82)

04. Wilfully Prevented, Interfered With, Or Attempted To Impede Work. Wilfully prevented, interfered with, or attempted to impede in any way the work of any duly authorized representative of the Director and the lawful enforcement of any provision of this chapter; or (1-1-82)

05. Preservation Of Evidence. Wilfully prevented or interfered with any representative of the Director in the preservation of evidence of any violation of any of the provisions of this chapter. (12-31-91)

315. -- 349. (RESERVED).

350. AUDITS.
The objectives of an audit are: (1-16-80)

01. Accuracy Of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (1-16-80)

02. Reliability Of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results to the provider's operations. (1-16-80)

03. Economy And Efficiency. To determine if Title XIX recipients have received the required care on a basis of economy and efficiency. (1-16-80)

04. Application Of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (1-16-80)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (1-16-80)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (1-16-80)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program recipients. (1-16-80)

08. Final Settlement. To effect final settlement when required by Sections 250 through 350 of this rule. (7-1-99)T

351. PRINCIPLE.
All financial reports will be subject to audit in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.12, "Rules Governing Audits of Providers". (4-28-89)

352. APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (1-16-80)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (1-16-80)

03. Additional Audits. In addition, audits may be required where: (1-16-80)

a. A significant change of ownership occurs. (1-16-80)

b. A change of management occurs. (1-16-80)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (1-16-80)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (1-16-80)

353. STANDARDS AND REQUIREMENTS.

01. Review Of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (1-16-80)

02. Requirements. Section 2404.3 of the August, 1973 revision of the Providers Reimbursement Manual (PRM) states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary." (7-1-99)T

03. Examination Of Records. Examination of records and documents may include, but not be limited to: (1-16-80)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (1-16-80)

b. Minutes and memos of the governing body including committees and its agents. (1-16-80)

c. All contracts. (1-16-80)

d. Tax returns and records, including workpapers and other supporting documentation. (1-16-80)

e. All insurance contracts and policies including riders and attachments. (1-16-80)

f. Leases. (1-16-80)

g. Fixed asset records (see audit section - Capitalization of Assets). (1-16-80)

h. Schedules of patient charges. (1-16-80)

i. Notes, bonds and other evidences of liability. (1-16-80)

j. Capital expenditure records. (1-16-80)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (1-16-80)

l. Evidence of litigations the facility and its owners are involved in. (1-16-80)

m. Documents of ownership including attachments which describe the property. (1-16-80)

n. All invoices, statements and claims. (1-16-80)

o. "Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit workpapers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request." (PRM, paragraph 2404.4(Q) of the Providers Reimbursement Manual) (7-1-99)T

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (1-16-80)

q. All patient records, including trust funds and property. (1-16-80)

r. Time studies and other cost determining information. (1-16-80)

s. All other sources of information needed to form an audit opinion. (1-16-80)

04. Adequate Documentation. (1-16-80)

a. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited (PRM, Section 2304). (7-1-99)T

b. Expenses. Adequate documentation would normally include: an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (1-16-80)

i. Date of service or sale; (1-16-80)

ii. Terms and discounts; (1-16-80)

iii. Quantity; (1-16-80)

iv. Price; (1-16-80)

v. Vendor name and address; (1-16-80)

vi. Delivery address if applicable; (1-16-80)

vii. Contract or agreement references; and (1-16-80)

viii. Description, including quantity, sizes, specifications brand name, services performed, etc.; (1-16-80)

c. Capitalization of Assets. Major movable equipment shall be capitalized. Minor movable equipment shall not be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset (PRM, Section 108.1). This rule shall apply except as to the provisions of Section 106 of PRM for small tools, etc. (7-1-99)T

i. Completed depreciation records must meet the following criteria for each asset: (1-16-80)

(1) Description of the asset including serial number, make, model, accessories, and location. (1-16-80)

(2) Cost basis should be supported by invoices for purchase, installation, etc. (1-16-80)

(3) Estimated useful life. (1-16-80)

(4) Depreciation method such as straight line, double declining balance, etc. (1-16-80)

(5) Salvage value. (1-16-80)

(6) Method of recording depreciation on a basis consistent with accounting policies. (1-16-80)

(7) Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (1-16-80)

(8) Reported depreciation expense for the year and accumulated depreciation shall tie to the asset ledger. (1-16-80)

ii. Depreciation Methods and Lives. (12-31-91)

(1) Methods. Straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (4-28-89)

(2) Depreciable Lives. The life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition Guidelines Lives, which is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (7-1-99)T

iii. Lease Purchase Agreements. Lease purchase agreements may generally be recognized by the following characteristics: (1-16-80)

(1) Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (4-28-89)

(2) Intent to create security interest; (1-16-80)

(3) Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (1-16-80)

(4) Noncancellable or cancellable only upon occurrence of a remote contingency; and (1-16-80)

(5) Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (1-16-80)

iv. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (12-31-91)

d. Personnel. Complete personnel records normally contain the following: (1-16-80)

i. Application for employment. (1-16-80)

ii W-4 Form. (1-16-80)

iii. Authorization for other deductions such as insurance, credit union, etc. (1-16-80)

iv. Routine evaluations. (1-16-80)

v. Pay raise authorization. (1-16-80)

vi. Statement of understanding of policies, procedures, etc. (1-16-80)

vii. Fidelity bond application (where applicable). (1-16-80)

05. Internal Control. (1-16-80)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (1-16-80)

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (1-16-80)

ii. Promoting accuracy and reliability in financial records. (1-16-80)

iii. Encouraging and measuring compliance with company policy and legal requirements. (1-16-80)

iv. Determining the degree of efficiency related to various aspects of operations. (1-16-80)

b. An adequate system of internal control over cash disbursements would normally include: (1-16-80)

i. Payment on invoices only, or statements supported by invoices. (1-16-80)

ii. Authorization for purchase such as a purchase order. (1-16-80)

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (1-16-80)

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (1-16-80)

v. Check of invoice accuracy. (1-16-80)

vi. Approval policy for invoices. (1-16-80)

vii. Method of invoice cancellation to prevent duplicating payment. (1-16-80)

viii. Adequate separation of duties between ordering, recording, and paying. (1-16-80)

ix. System separation of duties between ordering, recording, and paying. (1-16-80)

x. Signature policy. (1-16-80)

xi. Prenumbered checks. (1-16-80)

xii. Statement of policy regarding cash or check expenditures. (1-16-80)

xiii. Adequate internal control over the recording of transactions in the books of record. (1-16-80)

xiv. An imprest system for petty cash. (1-16-80)

06. Accounting Practices. Sound accounting practices normally include the following: (1-16-80)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (1-16-80)

b. Chart of accounts. (1-16-80)

c. A budget or operating plan. (1-16-80)

354. PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (1-16-80)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (1-16-80)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (1-16-80)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (1-16-80)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (9-1-85)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (1-16-80)

03. Fund Management. Proper management of such funds would include the following as minimum: (1-16-80)

a. Savings accounts, maintained separately from facility funds. (1-16-80)

b. An accurate system of supporting receipts and disbursements to patients. (1-16-80)

c. Written authorization for all deductions. (1-16-80)

d. Signature verification. (1-16-80)

e. Deposit of all receipts of the same day as received. (1-16-80)

f. Minimal funds kept in the facility. (1-16-80)

g. As a minimum these funds must be kept locked at all times. (1-16-80)

h. Statement of policy regarding patient's funds and property. (1-16-80)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (1-16-80)

j. System of periodic review and correction of policies and financial records of patient property and funds. (1-16-80)

355. DRUGS.
The rules governing payment for prescription drugs to outpatients are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Sections 126 through Subsection 090.01, "Rules Governing Medical Assistance". (12-31-91)

01. Nonlegend Drugs. (7-1-93)

a. For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, but not limited to, adjustments by discounts or terms. (9-1-85)

b. For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the Division of Medicaid. (7-1-99)T

02. Record-Keeping Requirements. According to requirements in the Providers Reimbursement Manual PRM, Section 2104, the provider, as part of its financial record keeping responsibility under the program, must have on supplier invoices all needed cost verification information including name brand, quantity, form and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Section 1815 of the Social Security Act and Section 405.453 of the regulations, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including, but not limited to, discounts (cash, trade, purchase and quantity), or rebates, must also be clearly reflected on the individual invoices or related documentation. (7-1-99)T

356. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions shall be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be that one which most clearly attains program objectives. (1-16-80)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 255. (12-31-91)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (1-16-80)

03. Other Actions. Generally overpayment shall result in two (2) circumstances: (1-16-80)

a. If the cost report is not filed the sum of the following shall be due: (1-16-80)

i. All payments included in the period covered by the missing report(s). (1-16-80)