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MEDICAID INFORMATION RELEASE MA26-18

To: All Nursing Facility Providers

From: Sasha O'Connell, Deputy Director

Subject: Update to Additional Terms Nursing Facility Provider Agreement

Idaho Medicaid is updating the terms of the Additional Terms – Nursing Facilities (attached) of the Medicaid Provider Agreement. Per the terms of the Medicaid Provider Agreement, section 1. Compliance:

“The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.”

This update is necessary to maintain the quality and safety of services provided, and align with updated operations. The updated Medicaid Provider Agreement will be effective September 7, 2026. Specific questions not answered by the materials referenced above can be directed to MCPT@dhw.idaho.gov.

SO/wd

The content of this guidance document is not new law but is an interpretation or application of existing law prepared by the Idaho Department of Health and Welfare to supply clarity to the public about existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing MCPT@dhw.idaho.gov or by calling 888-528-5861.

State of Idaho
Medicaid Provider Agreement
Additional Terms – Nursing Facilities
Part I: Private Nursing Facilities

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, “Additional Terms – Nursing Facilities” in accordance with the Medicaid Provider Agreement, as amended. PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.26 - "Medicaid Plan Benefits."

A-1. Allowable Costs

The following definitions and explanations apply to allowable costs:

A-1.1. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable.

A-1.2. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

A-1.3. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300.

A-1.4. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable.

A-1.5. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in IDAPA 16.03.26.050. NF AND ICF/IID REIMBURSEMENT. In determining the

reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:

- a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.
- b. Supplies and services provided for the owner's personal use.
- c. Compensation paid by the facility to employees for the sole benefit of the owner.
- d. Fees for consultants, directors, or any other fees paid regardless of the label.
- e. Keyman life insurance.
- f. Living expenses, including those paid for related persons.

A-1.6. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility.

A-1.7. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Idaho Code §56-108. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight-line basis and prorated over the estimated useful life of the asset.

A-1.8. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met.

A-1.9. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics.

A-1.10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable.

A-1.11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

A-1.12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

A-1.13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers.

A-1.14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care.

A-1.15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

A-1.16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein.

A-1.17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs.

A-1.18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable.

A-1.19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For free-standing nursing facilities, the property rental rate is paid as described in Idaho Code §56-108. Hospital-based nursing facilities are paid based on property costs.

- a. Amortization of leasehold improvements will be included in property costs.

- i. Straight line depreciation on fixed assets is included in property costs.

- ii. Depreciation of moveable equipment is an allowable property cost.

- b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

A-1.20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year.

A-1.21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care.

A-1.22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost.

A-1.23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable.

A-1.24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs.

A-2. Nonallowable Costs

The following definitions and explanations apply to nonallowable costs:

A-2.1. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable.

A-2.2. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable.

A-2.3. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable.

A-2.4. Charity Allowances. Cost of free care or discounted services are nonallowable.

A-2.5. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1.

A-2.6. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2.

A-2.7. Goodwill. Costs associated with goodwill as defined in Idaho Code §56-101 are nonallowable.

A-2.8. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A.

A-2.9. Interest. Interest to finance nonallowable costs are nonallowable.

A-2.10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable.

A-2.11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable.

A-2.12. Organization. Organization costs are nonallowable, see PRM, Section 2134.

A-2.13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable.

A-2.14. Prescription Drugs. Prescription drug costs are nonallowable.

A-2.15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2.

A-2.16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated.

A-2.17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

A-2.18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable.

A-2.19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable.

A-2.20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs.

A-3. Property and Utility Costs

A-3.1. Whether or not each of these cost items is allowed will be determined in accordance with other provisions of IDAPA 16.03.26 or these additional terms, or the PRM in those cases where IDAPA 16.03.26 rules are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal.

A-3.2. Depreciation. All allowable depreciation expense.

A-3.3. Interest. All allowable interest expense relating to financing building and equipment purchases.

A-3.4. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs.

A-3.5. Lease Payments. All allowable lease or rental payments.

A-3.6. Property Taxes. All allowable property taxes.

A-3.7. Utility Costs. All allowable expenses for heat, electricity, water and sewer.

A-4. Components of Nursing Facility Rate Methodology

A-4.1. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1 are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th).

A-4.2. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited cost report that ended in the calendar year two (2) years prior (for example, cost reports ending during the period from January 1, 2019 - December 31, 2019 are used in setting rates effective July 1, 2021). The draft audit of a cost report submitted by a facility will be issued by the

Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.

A-4.3. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows:

- a. The direct care per diem price applicable to the rate period for a nursing facility type (free- standing and urban hospital-based nursing facility, rural hospital-based nursing facility, free-standing and urban hospital-based behavioral care unit, or rural hospital-based behavioral care unit) is identified.
- b. A calculated reimbursement floor is calculated for each provider. To calculate the reimbursement floor, the identified direct care price is multiplied by (1 - a margin cap percentage). The margin cap percentage applied to the price for each facility is based on the quality payment tier, as determined through the Quality Payment Program. The margin cap percentages were established at the time of the rate system development and will be periodically reviewed for reasonableness, effectiveness, and efficiency. The higher the tier a provider falls in, with tier one (1) being the highest, the higher the margin percent. The difference between the calculated direct care price and the calculated reimbursement floor is the maximum margin payment available to the facility.
- c. The provider's calculated direct care case mix neutral cost is compared to the calculated reimbursement floor. The case mix neutral cost is derived from the facility's calculated direct care cost per day divided by the facility wide case mix index for the cost reporting period. If the case mix neutral cost is less than the floor, then the difference between the provider's calculated floor and case mix neutral cost is calculated.
- d. If the facility's calculated case mix neutral direct care cost is less than the direct price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:
 - i. The difference between the direct care price for the nursing facility type minus the calculated floor, as described in b. above; or
 - ii. The difference between the direct care price for the nursing facility type minus the facility's calculated case mix neutral direct care cost.
- e. The direct care component will be established at the lessor of the following:
 - i. The direct care price for the nursing facility type;
 - ii. The facility's case mix neutral direct cost plus the margin calculated in d. above.
- f. Exceptions for cases of lower direct care price:
 - i. If the direct care price for the nursing facility type is lower, the price, minus the raw food and Medicaid related ancillary portion of the calculated direct care price, is multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. The raw food and

Medicaid related ancillary portion of the price is then added back to arrive at the direct care cost component.

ii. If the direct care case mix neutral cost plus margin is lower, these costs, minus raw food and Medicaid related ancillary costs, are multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component.

A-4.4. Indirect Care Cost Component. The indirect care cost component of a nursing facility's rate is determined as follows:

- a. The indirect per diem price is applicable to the rate period for a nursing facility type, free-standing and urban hospital-based nursing facilities including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers is identified.
- b. A calculated reimbursement floor is calculated for each facility. To calculate the reimbursement floor, the identified indirect care price is multiplied by (1 - a margin cap percentage). The margin cap percentage applied for each facility is the same for all nursing facility types. The margin cap percentage was established at the time of the rate system development and will be periodically reviewed for reasonableness, effectiveness, and efficiency. The difference between the calculated indirect care price and the calculated reimbursement floor is the maximum margin payment available to the facility.
- c. The facility's calculated indirect care cost is compared to the calculated reimbursement floor. If the cost is less than the floor, then the difference between the facility's calculated floor and cost is calculated.
- d. If the facility's calculated indirect cost is less than the indirect price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:
 - i. The difference between the indirect care price for the nursing facility type minus the calculated floor, as described in b. above; or
 - ii. The difference between the indirect care price for the nursing facility type minus the facility's calculated indirect care cost.
- e. The indirect care component will be established at the lessor of the following:
 - i. The indirect price for the nursing facility type;
 - ii. The facility's indirect cost plus the margin calculated in d. above.

A-4.5. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates.

A-4.6. Property Reimbursement. The property reimbursement component is calculated in accordance with Idaho Code §56-108 and section A. 19. of these additional terms.

A-4.7. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s).

A-4.8. Budget Adjustment Factor (BAF). A total budget for nursing facility reimbursement will be established by legislature and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A budget adjustment factor will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled.

A-4.9. NURSING FACILITY: PRICE LIMITS BASED ON COST REPORT. Each July 1st, cost price limitations will be established for nursing facilities based on the audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1 (July 1, 2021 price limits will use cost reports ended in calendar year 2019 and so forth), including inflation adjustments from the mid-point of the cost report period to the mid-point of the rate period. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year.

a. Percentage Above Bed-Weighted Median.

i. Prior to establishing the first rates at July 1, 2021, the estimated Medicaid payments under the previous prospective system for the period from July 1, 2018, through June 30, 2019, were calculated. This amount was used to model the estimated payments under the case mix system set forth in IDAPA 16.03.26.482 NF: RATE SETTING, IDAPA 16.03.26.483 NF: PRINCIPLE FOR RATE SETTING, and IDAPA 16.03.26.484 NF: RATE DEVELOPMENT. The percentages above the bed-weighted median, for direct and indirect costs, were established at a level that approximated the same amount of Medicaid expenditures as would have been produced by the previous prospective system. The percentages were established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the previous prospective system.

ii. Once the percentages were established, they were used to calculate the limit by multiplying the bed-weighted median per diem cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities.

iii. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units.

iv. The percentages used for each class of nursing facilities was determined and agreed upon during the rate system workgroup meetings. These percentages will be evaluated periodically for reasonableness, effectiveness, and efficiency.

b. Direct Price Limits. The direct price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with all nursing facilities included in the same array, and the bed-weighted median will be computed.

c. Indirect Price Limits. The indirect price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with all nursing facilities included in the same array, and the bed-weighted median will be computed.

d. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in IDAPA 16.03.26.492. NF: OCCUPANCY ADJUSTMENT FACTOR.

A-4.11. Calculation of New Beds.

a. Limitation of Facility's Rate. Starting with rates effective July 1, 2021, the facility's rate will be limited to the bed-weighted average of the following two (2) rates:

i. The facility's current prospective rate calculated in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT; and

ii. The lesser of the following:

a. The current median rate for nursing facilities of that type, free-standing, free-standing with a BCU, rural hospital-based, rural hospital-based with a BCU or urban hospital-based, established each July 1st, reduced by ten percent (10%); or .

b. The nursing facility's current prospective rate calculated in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT of these rules, reduced by ten percent (10%).

b. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate.

c. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes:

- i. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed.
- ii. Beds added as a result of expansion plans, that the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria.
- iii. Beds that are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department.
- iv. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an underserved area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the reimbursement rate is negotiated with the Department.

A-4.12. Treatment of a Change of Ownership. New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate, inflated forward to the appropriate cost reporting year, until such time as the new owner has a cost report that qualifies for the rate setting criteria established under these rules. If a new owner is subject to receiving the prior owner rate for a third-rate year, the calculated rate for the third rate year will be the higher of the prior owner rate, inflated to the appropriate cost reporting year or the statewide median rate

calculated for that nursing facility class. If the Department determines that such a facility is operationally or financially unstable, the Department may negotiate a reimbursement rate different than the rate then in effect for the facility.

A-4.13. Treatment of New Facilities.

a. Any new facilities that were in the planning stages prior to July 1, 2021 or who were qualified to receive the New Facility Rate on July 1, 2021, will be grandfathered in for rate setting purposes. These facilities will be reimbursed at the median rate for the skilled care facilities of that type (freestanding or hospital-based) for the first four (4) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. After the first four (4) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with IDAPA 16.03.26.484. NF: RATE DEVELOPMENT.

i. The Year Four (4) calculation will allow for a 4% increase to the BAF adjusted non-property rate components. Providers whose rate is at the median and has a building age other than zero (0), the property rate will be replaced to reflect a building age of zero (0). The property rate will be replaced with a building age of zero (0), including the BAF adjustment.

b. Facilities constructed on or after July 1, 2023, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first four (4) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type, reduced by 10%. After the first four (4) full years, the facility will have its rate established at the next July 1st with the existing facilities.

A-4.14. Occupancy Adjustment Factor. In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows:

a. **Occupancy Levels.** If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Idaho Code §56-101. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs.

b. **Occupancy Adjustment.** For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or

the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities.

c. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories.

d. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure.

e. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment.

A-4.15. Reporting System. The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow:

a. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs.

b. Disclosure. Adequate financial disclosure.

c. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis.

d. Criteria. Criteria for evaluating policies and procedures.

A-4.16. Reporting System Principle and Application. The provider will be required to file mandatory annual cost reports.

a. Cost Report Requirements. The fiscal year end cost report filing must include:

i. Annual income statement (two (2) copies);

ii. Balance sheet;

iii. Statement of ownership;

iv. Schedule of patient days;

v. Schedule of private patient charges;

vi. Statement of additional charges to residents over and above usual monthly rate; and

vii. Other schedules, statements, and documents as requested.

b. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance.

c. Criteria of Reports. All reports must meet the following criteria:

i. State-approved formats used.

ii. Presented on accrual basis.

iii. Prepared in accordance with generally accepted accounting principles and principles of reimbursement.

iv. Appropriate detail provided on supporting schedules or as requested.

d. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant.

e. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements.

f. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met:

i. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the charge. This report must meet the criteria for annual cost reports, except that it is not filed later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. Outgoing management or administration of a facility being reimbursed on a prospective basis at the time of change will not be required to file a closing cost report. The Department reserves the right to not initiate an audit of a cost report filed by a prior owner if the ownership change occurs between the fiscal period end date of the last cost report filed and the first date of the applicable rate period.

ii. The Department may require an appraisal at the time of a change in ownership.

iii. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report.

A-4.17. Reporting Period. For purposes of nursing facility rate setting, cost report periods of less than one hundred and eighty-four days (184) days will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is one hundred and eighty-four days (184) days or more will be used until a cost report that includes one hundred and eighty-four days (184) days or more is received from the new owner, or is based on the new fiscal year.

A-5. Appeals and Administrative Review

Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

State of Idaho
Medicaid Provider Agreement

Additional Terms – Nursing Facilities

Part II: Behavioral Care Units

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, “Additional Terms – Behavioral Care Units” in accordance with the Medicaid Provider Agreement, as amended.

A-1. Determination. The Behavioral Care Unit (BCU) must have a qualifying program and have been providing care in the BCU to behavior residents as of July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility.

A-2. Nursing Facility: Existing Provider Elects to Add Behavioral Care Unit (BCU).

A-2.1. The direct cost portion of the rate will be calculated by determining ten percent (10%) below the median direct cost portion for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct cost portion of the rate will be set at ten percent (10%) below the median rate of existing BCUs. The direct cost portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Section A-2.3. of these additional terms. At no time will the direct cost portion be lower than the direct cost median of the non-BCU providers for that nursing facility type.

A-2.2. The provider’s total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers.

A-2.3. Once the provider has a twelve-month (12) cost report that contains a full year of BCU costs, their rate will be calculated in the same manner as other providers in accordance with IDAPA 16.03.26, “Medicaid Plan Benefits” and Medicaid Provider Agreement Additional Terms – Nursing Facilities.

A-2.4. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Sections A-1 through A-15 of these additional terms. If the provider was not a BCU for a full cost report year, the thirty percent (30%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year.

A-2.5. If a nursing facility who previously qualified as a BCU does not meet the minimum requirements upon annual application, they must wait one (1) year from the date of BCU denial before they may apply again for BCU status.

A-3. Annual Enrollment. Once an annual rate has been set as provided in Section A-15 of these additional terms, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by:

A-3.1. BCU days, regardless of payer source, are divided by the total occupied days in the nursing facility and that calculation equals or exceeds a minimum of thirty percent (30%).

A-3.2. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year;

a. The Department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the Minimum Data Set (MDS) for each selected sample participant, along with related census information, and other requested information to the Department.

b. The Department will review this information to determine that the participants meet the requirements of Section A-10 of these additional terms and calculate the percentage of BCU days to the total occupied days in the facility to determine whether the facility meets the BCU eligibility requirement in these additional terms.

A-4. BCU Annual Renewal. The facility must request continuation in the BCU program annually including the following documentation:

A-4.1. A description of the facility's program that includes the required components in Section A-10 of these additional terms; and

A-4.2. A profile of the types of behavior of participants served and any restrictions the facility has adopted.

A-5. Termination of BCU Status.

A-5.1. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year.

A-5.2. If a provider does not meet BCU qualifications during the renewal period, they must wait one year to re-apply for BCU status. If the provider re-applies within one to two (1 – 2) years of the non-qualifying period, they receive their actual direct care cost, subject to the BCU price. If the provider re-applies three (3) years after the non-qualifying period, they will receive the direct care median rate of other BCU providers, reduced by ten percent (10%).

A-6. Administrative and Staffing Requirements.

A-6.1. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed.

A-6.2. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for twenty-four hours a day/seven days a week

(24/7) emergency services. Consultants must make at least quarterly site visits and be available to participate in behavior management team meetings as needed.

A-6.3. Licensed master social worker (LMSW), licensed professional counselor (LPC), or licensed social worker (LSW) with behavioral experience must be available to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and behavior management team meetings as needed.

A-7. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on:

A-7.1. Assessment and prevention;

A-7.2. Medication and side effects;

A-7.3. Effects of disease process on mood state;

A-7.4. Safety techniques;

A-7.5. Deflecting aggression or target behaviors;

A-7.6. Comprehensive environmental intervention;

A-7.7. Stress management; and

A-7.8. Documentation and charting.

A-8. Quarterly Training. In addition to annual training requirements as outlined in Section A-7 of these additional terms, BCUs will provide quarterly education to direct care staff aimed at enhancing neurocognitive, behavioral health, and behavior management knowledge and skill sets. Examples of such education include but are not limited to: the physiology of neurocognitive diseases and mental illnesses, antipsychotic/antidepressant effects on elderly populations, evidenced based practice behavior management techniques and strategies, and review of the Medicaid BCU program. Quarterly education can be conducted by: a qualified facility staff person, online courses, webinars, conferences, seminars or guest speakers.

A-9. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed and may participate in person or by telephone.

A-10. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in documentation requested by the Department:

A-10.1. Medically based behavior disorder that causes a significantly diminished capacity for judgment, retention of information, or decision-making, or medically based mental health disorder of diagnosis and has a high-level resource use; and

A-10.2. Must have a history of need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff; demonstrated

by documentation of the frequency of occurrences, and the extra resources required, for a minimum of three (3) separate days within a seven (7) day period each week for three (3) consecutive months, Disruptive behaviors are evidenced by three (3) or more of the following within a given week as defined by the Idaho Medicaid Provider Handbook:

- a. Wandering behaviors;
- b. Verbally abusive behaviors;
- c. Physically abusive behaviors;
- d. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents;
- e. Behaviors that resist care; or
- f. Does not meet unit discharge criteria outlined below

A-10.3. A behavior baseline profile must be established for each participant within thirty (30) days of admission;

A-10.4. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or safety.

A-11. Refusal of Admissions. The provisions of this agreement do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility.

A-12. Care Planning, Behavioral Management, and Programming. Participants must have, with documentation, individualized care plans, based on assessments of cognitive and functional abilities that contains behavioral analysis used to create a strategy for prevention and intervention, which includes:

A-12.1. Thirty (30) day assessments of progress completed and reviewed by the facility's behavioral management team.

A-12.2. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used.

A-12.3. Attempts to involve family and responsible parties with the participant through visits, training, outings, or appropriate communications.

A-12.4. Recreational and activity programming targeted to specific needs and exhibited behaviors.

A-12.5. Integration for appropriate social interactions must be used when appropriate.

A-12.6. Community for transition must be used when appropriate for each individual participant.

A-12.7. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming.

A-13. Discharge Criteria. The BCU must discharge a participant, and document, when one of the following is present:

A-13.1. Improvement in ability to function that would enable transfer to less-restrictive environment.

A-13.2. Lack of benefit from specialized programs offered in BCU.

A-13.3. Consistent refusals by participant or responsible party to allow interventions that are determined to be helpful.

A-13.4. Acute danger to self or others that cannot be managed by staffing in the BCU.

A-13.5. Acute physical illness or complications requiring a higher level of medical care than available in the facility.

A-14. BCU Routine Customary Charge. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU.

A-15. Prospective Rate Setting. Rates will be calculated using the cost report ended in the calendar year two (2) years prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit.

A-16. Reimbursement for Years One (1) Through Four (4) of Newly Licensed Facilities with BCUs. Beginning with the first day of the first month following approval of the BCU license and when the provider can demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty-day period, equals or exceeds a minimum of thirty percent (30%), the provider's rate will change to reflect BCU services. The provider will be reimbursed at ten percent (10%) below the median rate for BCU facilities of that type, either freestanding or hospital-based, for the remaining period within the first four (4) full years of operation. The rates will be updated annually on July 1. If there are no facilities of the same type (for example, no other hospital-based BCUs), the provider will receive ten percent (10%) below the median rate for their type, but the direct cost portion of the rate will be revised to the ten percent (10%) below the median rate of existing BCUs. At no time will this rate be set below the median rate for the non-BCU providers of that nursing facility type. The rate change to reflect BCU services will not be retroactive to rate quarters paid prior to meeting the thirty percent (30%) BCU occupancy requirement.

A-16.1. If the provider did not meet the BCU qualifications described in Sections A-4 through A-13 of these additional terms, for a full cost report year corresponding to the initial application year, the thirty percent (30%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year.

A-16.2. After the first four (4) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Sections A-15 and A-10 of these additional terms.

A-16.3. During the period of limitation, providers must demonstrate annually that BCU days were equal to or exceeded thirty percent (30%), as described in IDAPA 16.03.26.489. NF: BCU QUALIFICATIONS. Providers must provide a report to the Department with a calculation of BCU days for each month during the period being reviewed. If the twelve-month (12) average falls below thirty percent (30%), then the BCU reimbursement will revert to the median rate. Once the Department has established the provider has met the requirements of IDAPA 16.03.26.489 NF: BCU QUALIFICATIONS they will be eligible for a new rate outlined in these additional terms.

A-17. Appeals and Administrative Review. Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

State of Idaho
Medicaid Provider Agreement

Additional Terms – Nursing Facilities
Part III: State Owned Nursing Facilities

The DEPARTMENT reserves the right to amend the following definitions, applicability, methodology components, and payment formulas outlined in this document titled, “Additional Terms – State Owned Nursing Facilities” in accordance with the Medicaid Provider Agreement, as amended.

A-1 Allowable Costs

The following definitions and explanations apply to allowable costs:

A-1.1. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable.

A-1.2. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

A-1.3. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300.

A-1.4. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable.

A-1.5. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in IDAPA 16.03.26.050. NF AND ICF/IID REIMBURSEMENT. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or

primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:

- a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.
- b. Supplies and services provided for the owner's personal use.
- c. Compensation paid by the facility to employees for the sole benefit of the owner.
- d. Fees for consultants, directors, or any other fees paid regardless of the label.
- e. Keyman life insurance.
- f. Living expenses, including those paid for related persons.

A-1.6. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility.

A-1.7. Depreciation. Depreciation on buildings and equipment is an allowable property expense. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset.

A-1.8. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met.

A-1.9. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics.

A-1.10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable.

A-1.11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

A-1.12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

A-1.13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers.

A-1.14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care.

A-1.15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

A-1.16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein.

A-1.17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs.

A-1.18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable.

A-1.19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this agreement and applicable regulations. Property taxes and reasonable property insurance are allowable for all facilities. State owned nursing facilities are paid based on property costs.

a. Amortization of leasehold improvements will be included in property costs.

i. Straight line depreciation on fixed assets is included in property costs.

ii. Depreciation of moveable equipment is an allowable property cost.

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

A-1.20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year.

A-1.21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care.

A-1.22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost.

A-1.23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable.

A-1.24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs.

A-2. Nonallowable Costs

The following definitions and explanations apply to nonallowable costs:

A-2.1. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable.

A-2.2. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable.

A-2.3. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable.

A-2.4. Charity Allowances. Cost of free care or discounted services are nonallowable.

A-2.5. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1.

A-2.6. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2.

A-2.7 Goodwill. Costs associated with goodwill as defined in Idaho Code §56-101 are nonallowable.

A-2.8. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A.

A-2.9. Interest. Interest to finance nonallowable costs are nonallowable.

A-2.10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable.

A-2.11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable.

A-2.12. Organization. Organization costs are nonallowable, see PRM, Section 2134.

A-2.13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable.

A-2.14. Prescription Drugs. Prescription drug costs are nonallowable.

A-2.15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2.

A-2.16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated.

A-2.17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

A-2.18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable.

A-2-19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable.

A-2-20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs.

A-3. Property and Utility Costs

A-3.1. Whether or not each of these cost items is allowed will be determined in accordance with other provisions of IDAPA 16.03.26 or these additional terms, or the PRM in those cases where IDAPA 16.03.26 rules are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal.

A-3-2. Depreciation. All allowable depreciation expense.

A-3.3. Interest. All allowable interest expense relating to financing building and equipment purchases.

A-3-4. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs.

A-3.5. Lease Payments. All allowable lease or rental payments.

A-3.6. Property Taxes. All allowable property taxes.

A-3.7. Utility Costs. All allowable expenses for heat, electricity, water and sewer.

A-4. Components of Nursing Facility Rate Methodology

A-4.1. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited cost report that ended in the calendar year two (2) years prior (for example, cost reports ending during the period from January 1, 2024 - December 31, 2024 are used in setting rates effective July 1, 2026). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.

A-4.2. Prospective Payment System. The per diem rates will be calculated separately from other nursing facilities. The per diem rate for State Operated Nursing Facilities shall be determined using the most recently desk reviewed or audited cost report and include an inflationary adjustment from the midpoint of the cost reporting period to the midpoint of the applicable rate period. The calculated rate will not be subject to the same price or other limits determined for prospective payments made to other nursing facilities and will not be case mix adjusted. The rate will be prospective and will be effective on July 1 of each state fiscal year. The designation as a state operated facility will be determined by the state.

a. For any newly constructed State Operated Nursing Facilities licensed on or after July 1, 2026, the prospective reimbursement rate will be set at the

median rate of the other State Operated facilities. Once the provider has a qualifying cost report, it will be used to set a prospective rate.

A-4.3. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding cost center.

A-4.4. Reporting System. The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow:

- a. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs.
- b. Disclosure. Adequate financial disclosure.
- c. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis.
- d. Criteria. Criteria for evaluating policies and procedures.

A-4.5. Reporting System Principle and Application. The provider will be required to file mandatory annual cost reports.

a. Cost Report Requirements. The fiscal year end cost report filing must include:

- i. Annual income statement (two (2) copies);
- ii. Balance sheet;
- iii. Statement of ownership;
- iv. Schedule of patient days;
- v. Schedule of private patient charges;
- vi. Statement of additional charges to residents over and above usual monthly rate; and
- vii. Other schedules, statements, and documents as requested.

b. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance.

c. Criteria of Reports. All reports must meet the following criteria:

- i. State-approved formats used.
- ii. Presented on accrual basis.
- iii. Prepared in accordance with generally accepted accounting principles and principles of reimbursement.
- iv. Appropriate detail provided on supporting schedules or as requested.

d. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant.

e. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements.

f. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met:

i. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the change. This report must meet the criteria for annual cost reports, except that it is not filed later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. Outgoing management or administration of a facility being reimbursed on a prospective basis at the time of change will not be required to file a closing cost report. The Department reserves the right to not initiate an audit of a cost report filed by a prior owner if the ownership change occurs between the fiscal period end date of the last cost report filed and the first date of the applicable rate period.

ii. The Department may require an appraisal at the time of a change in ownership.

iii. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report.

A-4.6. Reporting Period. For purposes of nursing facility rate setting, cost report periods of less than one hundred and eighty-four (184) days will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is one hundred and eighty-four (184) days or more will be used until a cost report that includes one hundred and eighty-four (184) days or more is received from the new owner, or is based on the new fiscal year.

A-5. Appeals and Administrative Review

Providers that disagree with the Department's calculation may request in writing for an administrative review pursuant to Idaho Code §56-133. If the provider disagrees with the administrative review decision, it may request an administrative appeal within twenty-eight (28) days of such decision.

FOR THE PROVIDER:

Administrator

Date

Name of Provider:_____

Address of Provider:_____

Phone: _____

Idaho Medicaid Provider Number:_____