114.2 CMR 2.00: RATES OF PAYMENT TO LONG-TERM CARE FACILITIES

Section

2.01 General Provisions

(1) Scope and Effective Date. 114.2 CMR 2.00 shall govern interim rates of payment effective October 1, 1990 and final rates of payment effective January 1, 1990.

(2) Authority. 114.2 CMR 2.00 is adopted pursuant to M.G.L. c. 6A, §§ 31 through 74.

(3) Description of Rate Setting System. The interim rate year for all long-term care facilities is the 12 month period beginning October 1, except for the period from October 1, 1990 through December 31, 1990, for those providers receiving an extended interim rate, as defined in 114.2 CMR 2.02, General Definitions, and as determined in accordance with 114.2 CMR 2.05(1). The provider receives an interim rate based on the adjusted costs of the preceding calendar year, updated by a cost adjustment factor, except for the period from October 1, 1990 through December 31, 1990 for providers receiving an extended interim rate. Following the close of the calendar year, the provider reports actual costs for the cost-reporting year, and a final rate is computed for the calendar year. For the same calendar year, the provider has previously received two interim rates: one covering the period January 1 through September 30 and the second covering the period October through December 31. The difference between the final rate and each of the two interim rates will result in two differential rates. The provider then receives from or pays to the Commonwealth the differential rate multiplied by the number of publicly-aided patient days for each period. Beginning January 1, 1990, those facilities which have been designated by the Department of Public Welfare to receive prospective case-mix rates pursuant to 114.2 CMR 5.00, Prospective Rates of Payment to Long-Term Care Facilities, will have rates set on a prospective basis without final settlement.

2.02: General Definitions

Meaning of Terms. As used in 114.2 CMR 2.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.2 CMR 2.02.

2.02: continued

Accurate, Detailed Financial Records. Complete documentation containing clear and compelling evidence of all of the financial transactions of the provider and affiliated entities as well as census activity, including but not limited to the books, invoices, bank statements, canceled checks, payroll records, including copies of governmental filings and time records, such as time cards and any other record which is necessary to provide the Commission with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for whom any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

Administrative Day. A day of acute inpatient hospitalization on which an appropriate placement is not available.

Administration Function. Those duties which are necessary to the general supervision and direction of the current operations of a long-term care facility, including, but not limited to: the hiring and firing of personnel; supervising of nursing, dietary, and other personnel; maintaining patient and other records; supervising the maintenance of and repairs to the home and procuring necessary supplies.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Allowable Operating Costs. The operating costs after the adjustments required by 114.2 CMR 2.00 have been applied to the provider's total operating costs as reported on the RSC-1 report.

Average Equity Capital. The average of the difference between a provider's allowable fixed asset basis calculated pursuant to 114.2 CMR 2.12 and the allowable long-term liabilities thereon at the beginning of the year and at the end of the year in accordance with 114.2 CMR 2.09. Mortgage acquisition costs such as capitalized legal fees and prepaid interest on long-term obligations will be considered allowable fixed assets for purposes of average equity capital provided that such costs are amortized over the life of the mortgage. However, capitalized interest income which has been generated from such funds shall not be included in average equity capital.

Commission. The Rate Setting Commission established under M.G.L. c. 6A, § 32.

Department. The Massachusetts Department of Public Health.

Equity Supplement. An amount equal to the annual building depreciation allowed by the Commission, incurred from July 1, 1976, or the date of construction of the facility, or the date of acquisition of the facility by the current owner, whichever is later, through December 31, 1982.

Extended Interim Rate of Payment. The *per diem* rate effective October 1, 1990 to December 31, 1990 for those facilities which have been designated by the Department of Public Welfare to receive prospective case-mix rates effective January 1, 1991. The interim rate effective October 1, 1990 to December 31, 1990 shall be computed in accordance with 114.2 CMR 2.05(1).

Final Rate of Payment. The *per diem* rate effective January 1 through December 31, determined by applying the provisions of 114.2 CMR 2.04 to audited costs and other data, as reported on the forms RSC-1, RSC-2, RSC-3 and accompanying schedules which the Commission may require, for the calendar year.

2.02: continued

Fixed Costs. Indirect patient care costs, as determined by the Commission, which are independent of level of occupancy, including interest associated with long-term debt, depreciation of buildings, building improvements and equipment, insurance on buildings and equipment, real estate taxes, rent, and the non-income related portion of the Massachusetts corporate excise tax.

Generally Available Employee Benefits. The employee benefits which are both reasonable and necessary for the efficient operation of the facility. Such benefits must be nondiscriminatory and may be available to part-time employees on a prorated basis.

Heavy Care Patient. A patient not in need of hospital level services but who is according to criteria established by the Department of Public Welfare:

(a) totally dependent in transferring, ambulating, bathing, dressing, and toileting and has no reasonable expectations of improvement; or

(b) totally dependent in transferring, bathing, dressing, and toileting, but able to ambulate with partial assistance or assistance devices and either consistently incontinent or extensively confused.

Heavy Case-Mix Intensity Facility. A facility or units thereof providing nursing, restorative and other therapeutic services and whose average management minutes is 148.1 minutes or more.

Interest Expense. The necessary and proper expense incurred for the use of legitimate loans to satisfy needs of the provider directly related to the provision of adequate patient care. Interest payments or charges based upon provider's receipts or income shall not be considered as interest expense.

Interim Rate of Payment. The *per diem* rate effective October 1 through September 30, determined by applying the provisions of 114.2 CMR 2.05 to the costs of the provider and such other data reported to the Commission for the most recently completed calendar year.

Licensed Bed Capacity. The available patient days, computed by multiplying the number of days in the applicable period by the number of beds licensed by the Department for use in the provider's long-term care facility.

Light Case-Mix Intensity Facility. A facility or units thereof providing nursing, restorative and other therapeutic services and whose average management minutes range from zero minutes to 132.0 minutes.

Long-Term Care Facility. A nursing or convalescent home as defined in M.G.L. c. 111, § 71, or a nursing facility of light, moderate or heavy case-mix intensity, operating under a hospital license issued by the Department pursuant to M.G.L c. 111, which is certified by the Department for participation in the State medical assistance program. For purposes of 114.2 CMR 2.00, long-term care facilities shall include those that operate a licensed residential care unit within the nursing facility.

Management Minutes. A method of measuring patient care intensity, or case mix, by discrete care-giving activities or the characteristics of patients found to require a given amount of care.

Moderate Case-Mix Intensity Facility. A facility or units thereof providing nursing, restorative and other therapeutic services and whose average management minutes range from 132.1 minutes to 148.0 minutes.

2.02: continued

Net Average Medicaid Accounts Receivable. Average monthly amounts billed to the Commonwealth of Massachusetts and for which payment has not vet been received. These shall be reduced by amounts due to the Commonwealth because of over payments. Net Average Medicaid Accounts Receivable shall not include any resource money or funds to be received from other sources.

Nursing Costs. Direct patient care personnel costs. The following are examples of nursing costs:
(a) Supervisor of Nurses
(b) Registered Nurses
(c) Licensed Practical Nurses
(d) Rehabilitation Nursing Assistants
(e) Nurses' Aides
(f) Orderlies
(g) Purchased Service - Nursing
(h) Payroll Taxes and Fringe Benefits of the above Personnel costs of Ward Clerks and Medical records Librarians will not be considered nursing costs.

Patient Days. The number of days of occupancy by patients in a facility. Included in the computation of patient days will be the day of admission but not the day of discharge. Where admission and discharge occur on the same day, one patient day will be used. Those days on which a bed is held vacant and reserved for a publicly-aided patient temporarily placed in a different care situation, pursuant to an agreement between the provider and the Department of Public Welfare in accordance with duly established policies of said Department, shall also be included as patient days. Those days on which a bed is held vacant and reserved for a nonpublicly-aided patient shall also be included as patient days.

Personnel. Definitions set out in the Department's Rules and Regulations for the Licensing of Long-Term Care Facilities (1977) (105 CMR 150.000) or its most recent applicable regulation shall apply for the following terms:
(a) Registered Nurse
(b) Licensed Practical Nurse
(c) Nurses' Aide or Orderly
(d) Dietitian
(e) Physical Therapist
(f) Occupational Therapist
(g) Speech Pathologist or Audiologist
(h) B.A. Social Worker and M.S.W. Social Worker or Social Worker complying with equivalency standards established by the Department
(i) Food Service Supervisor
(j) Health Service Supervisor
(k) Director of Nurses
(1) Supervisor of Nurses
(m) Medical Director

Policy Planning Function. The policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of a long-term care facility, including but not limited to the following: the financial management of the facility, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of patient admission policies and the planning of the expansion and financing of the facility.

Provider. A long-term care facility providing care to publicly-aided patients.

2.02: continued

Prudent Buyer Concept. The assumption that any amount paid by a provider above the market price for a supply or service is an unreasonable cost and shall be excluded from reimbursable costs.

Public Medical Institutions (PMI). Long-term care facilities which are operated by a municipality.

Publicly-Aided Patients. A person for whose care in a long-term care facility the Commonwealth or a political subdivision of the Commonwealth is in whole or in part financially liable.

Reasonable Operating Costs. Those costs incurred by a provider which are reasonable and necessary in providing adequate care to publicly-aided patients and which are within the requirements and limitations of 114.2 CMR 2.00. The reasonableness and necessity of any cost shall be determined by reference to or in comparison with the cost of providing comparable services and by reference to the prudent buyer concept.

Related Party. A person or organization which is associated or affiliated with or has control of or is controlled by the provider or is related to the provider or any director, stockholder, trustee, partner or administrator of the provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% shall be the operative factor as set out in sections 267(b)(2) and (3) and provided further that the definition of "family members" found in section 267(c)(4) of said code shall include, for the purposes of 114.2 CMR 2.00, spouses and lineal descendants of the individuals' brothers and sisters, brothers and sisters of the individual's spouse as well as spouses and lineal descendants of same and lineal ancestors of the individual's spouse.

Reports. The annual filings provide for in 114.2 CMR 2.03.

Required Education. Educational activities, conducted within the Commonwealth of Massachusetts by a recognized school or authorized organization, that are required for maintaining a professional license of employees delivering and/or improving patient care to publicly-aided patients. Required education also includes the training of all nurses' aides.

Special Care Patient. A patient not in need of hospital level services but who, according to criteria established by the Department of Public Welfare, needs one or more of the following:

(a) intensive feeding assistance (requires 40+ minutes per major feeding) and/or tube feeding;

(b) decubitus ulcer debridement/dressing changes (requires at least two skilled nursing home hours per day);

(c) short-term IV therapy (requires use of IV fluids and/or medications intermittently as needed or continuously for not longer than ten days); or

(d) chronic respiratory/pulmonary therapy (suctioning, pulmonary toileting, inhalation therapy).

(e) control of a severe behavior management problem (requires nursing or nurse's aide staff to calm, support, or protect the patient or others in the nursing home because of a consistent pattern of assaultive and/or combative behavior, frequently recurring bursts of screaming, or frequently occurring refusal to comply with other requirements of the home; such staff services are utilized instead of tight restraints or in conjunction with loose restraints).

Total Bed Capacity. The number of patient days obtained by multiplying the number of days in the applicable period by the maximum number of beds which a facility may accommodate consistent with the fire safety and other physical environment standards applicable to it under state and federal law, whether or not the facility is presently licensed to operate all such beds. In no case, however, shall total bed capacity be considered less than licensed bed capacity.

2.02: continued

Unit. Unit shall have the same definition as in the Department's Rules and Regulations for the Licensing of Long-Term Care Facilities (1977) (105 CMR 150.000) or its most recent applicable regulation.

Variable Costs. Direct patient care costs which are dependent on level of occupancy. The following are examples of items which shall not be considered variable costs:

(a) administrators' salaries
(b) real estate taxes
(c) interest associated with long-term debt
(d) building improvement and equipment depreciation
(e) bad accounts
(f) Massachusetts and federal taxes, refunds and allowances
(g) owners and officers' salaries
(h) rental expenses

Wage Survey: Two different surveys will be collected each year in all long-term care facilities in the Commonwealth.

(a) A quarterly survey that collects payroll information on nursing, non-nursing, and temporary pool personnel.

(b) An annual survey that collects payroll information for a specific period, on administration and policy planning personnel.

2.03: Required Reports

(1) Annual Filings. Providers shall annually complete on an accrual basis, and file the Commission's RSC-1 report and, if applicable, the RSC-2 report for realty companies and RSC-3 report for management companies collectively referred to as the Reports. Providers shall also complete and file the Commission's Wage Surveys. Copies of the Reports and Wage Surveys are attached hereto and incorporated herein by reference. Accurate detailed financial records substantiating the reported costs must be maintained for a period of at least three years following the submission of such Reports or until the final resolution of any appeal involving a rate for the period covered in the Report, whichever is later. Providers that claim management or central office expense must file an RSC-3 form. If additional management or central office expense is claimed through more than one entity, each additional entity must file a management or central office expense report which should be identified as RSC-3A, B, etc. When filing these forms and incorporating such costs into the claim for reimbursement, the provider must certify that such costs are both reasonable and necessary for the care of publicly-aided patients in Massachusetts. Management or central office organizations are subject to the same personnel and administrative standards as individual facilities. For example, written job descriptions for all positions including qualifications, duties, responsibilities and time records as required by 105 CMR 150.002 (D)(1) will be maintained by management companies in order to have personnel costs considered for reimbursement.

(2) Filing Dates.

(a) Reports. Each long-term care facility, including public medical institutions, shall submit the Reports for the calendar year and other information which the Commission may require on or before May 1 of each year. Where there has been a change in ownership, the transferor shall file the Reports within 45 days after the transfer of ownership. New facilities and additions receiving a special interim rate under 114.2 CMR 2.13 must file a cost report within 30 days after completion of the first six months of operation. Where a facility is under the supervision of a Patient Protector Receiver pursuant to M.G.L. c. 111, § 72N or in the case of a trustee in bankruptcy, all costs reports for the period prior to the date of such appointment shall be filed within 45 days of said appointment. Reports which are filed after May 1 shall be subject to sanctions as described in 114.2 CMR 2.03(7).

2.03: continued

(b) Wage Surveys. Each long-term care facility shall file two wage surveys for the calendar year as follows:

1. The annual Administrator's Wage Survey shall be submitted on or before July 18.
2. The quarterly wage survey of nursing, non-nursing and temporary pool personnel shall be filed on or before January 18, April 18, July 18, and October 18 wherein the facility reports payroll information from the quarter prior to submission.

(3) Extension of Filing Date. The Chairman of the Commission may grant an extension of time for submission of the Reports and other information which the Commission may require. No extension is required for reports filed between March 31 and May 1. For extensions beyond May 1, the provider must show that exceptional circumstances exist precluding said provider from submitting the Reports by May 1. The filing of such request must be submitted to the Commission by April 1 in order for the provider to be notified of the Commission's findings by May 1. In no case shall extensions be granted for more than 30 days past May 1 of each year. The Chairman may also extend, up to 30 days, filing dates for wage surveys.

(4) Complete Submission. Within 60 days of receipt of the Reports, the Commission shall notify the provider if it finds the submission to be incomplete and shall specify what additional information is required to complete the submission. Upon receipt of a complete submission, the Reports and all accompanying schedules shall be deemed to be filed with the Commission. If the Commission fails to notify the provider within the 60 day period, the submission shall be considered complete and the Reports and all accompanying schedules shall be deemed filed with the Commission as of the date of receipt.

(5) Amended Reports. For the purpose of establishing the interim rate of payment effective October 1, amended Reports will be accepted no later than the preceding July 15. For the purpose of establishing the final rate of payment effective for the calendar year, amended Reports will be accepted no later than July 15 of the year following the close of said calendar year. Amended reports must be accompanied by a complete list of all changes and an explanation of the reasons therefor.

(6) Additional Information. Any provider who fails to maintain records, as required by 114.2 CMR 2.03(1), including time records for all personnel as required in 105 CMR 150.002(D)(1), shall have excluded from its rate any cost or item for which such reports were not maintained. Any record not produced at the request of Commission personnel during an audit or through a request pursuant to 114.2 CMR 2.03 shall be deemed not to have been maintained for purposes of the application of 114.2 CMR 2.03.

(7) Failure to File Timely.

(a) Where a long-term care provider has failed to file the required Reports by May 1, no interim rate will be promulgated. In such cases, an interim rate will be promulgated effective the first day of the sixth month following the receipt of an acceptable cost report.

Example: Where a provider files the Reports on May 17, 1990, an interim rate which would normally be effective on October 1, 1990 will be effective on November 1, 1990. Where a provider files the Reports on June 8, 1990, an interim rate which would normally be effective on October 1, 1990 will be effective on December 1, 1990. The deferral of the effective date shall not apply in cases when the newly-established rate is lower than the prior rate. In cases where the Commission has notified the provider that the Reports are incomplete, the application of this provision shall be deferred 30 days from the date of such notice.

Example: Where a provider files the Reports on April 3, 1990 and the Commission notifies the provider on April 13, 1990 that it finds the submission incomplete, if the provider refiles corrected Reports by May 13, 1990, the deferral of the effective date of the next interim rate shall not apply.

2.03: continued

Where a provider has failed to file reports or other required information for a period of nine months after the filing date, the Commission shall notify the provider of this failure and of the sanctions which shall be imposed. Notifications shall be sent registered mail, return receipt requested. 30 days following said notice, the Commission shall reduce the provider's rate to zero unless the failure to file is cured within said 30 days.

(b) Wage Surveys. Providers failing to file the nursing and the administration wage surveys timely, shall be notified by the Commission of this failure by registered mail, return receipt requested. Where the Commission has approved a provider's request for extension, the wage survey will be considered timely-filed if the provider files the wage survey by the extension deadline. The sanction for each month a quarterly survey is late shall be one month's loss of eligibility for incentives, described in 114.2 CMR 2.16(7), in the provider's 1990 final rates. The sanction shall be applied separately for each required quarterly wage survey.

Example: Where the provider files the nursing wage survey due on July 18, 1990 on July 20, 1990, the provider shall lose eligibility for any incentives for the month of January 1990. If the provider does not file the survey until August 20, 1990, the provider shall lose eligibility for any incentives for the months of January and February 1990. Furthermore, if the provider files the wage survey due on October 18, 1990 on October 20, 1990, the provider shall lose eligibility for any incentives for an additional month, thus losing it for January, February and March of 1990.

(8) Termination of Provider Contract. When a provider contract between the provider and the Department of Public Welfare has been terminated, the provider shall file reports covering the current reporting period or portion thereof covered by the contract, and any other Reports required by the Commission, within 60 days of such termination. When the provider fails to file the required Reports in a timely fashion, the Commission shall establish a zero final rate for each period for which the provider has failed to file the Reports. Such zero final rates will be amended when the requested Reports are filed. Facilities that are under the supervision of a Patient Protector Receiver appointed pursuant to M.G.L. c. 111, § 72N or a trustee in bankruptcy will be treated as a termination of provider contract for purposes of 114.2 CMR 2.03(8). For example, if a Patient Protector Receiver is appointed on August 15, 1990, the cost report for the period January 1, 1990 to August 14, 1990 and all prior reports are due on October 14, 1990. After that date, the above zero rate process will begin.

(9) Quarterly Reports. Each provider shall file a copy of the Division of Employment Security Employer's Quarterly Tax Report Form 1. Reports for quarters ending March 31, June 30, September 30 and December 31 must be filed not later than April 30, July 31, October 31 and January 31, respectively. Nonprofit providers that are not subject to Employment Security requirements shall file Form 941, Employer's Quarterly Federal Tax Return in lieu of the Employment Security form.

2.04: Principles for Determining Final Rate of Payment

(1) Final *Per Diem* Rate. The final rate of payment effective for long-term care facilities for the 12 month period beginning January 1 shall represent the sum of the elements set out in 114.2 CMR 2.06 through 2.11 and, where appropriate, 114.2 CMR 2.16(7), each computed for the calendar year on a *per diem* basis. Costs and expenses included in determining a provider's final rate of payment are subject to all limitations and conditions set forth in 114.2 CMR 2.00. In the case of long-term care facilities which include resident care units, separate *per diem* rates shall be computed for those beds licensed for resident care. Where there has been a change in ownership, separate final rates shall be established for the period of ownership of the transferor and for the period of ownership of the transferee.

2.04: continued

(2) Computation of Final *Per Diem* Rate. When the licensed bed capacity is equal to the total bed capacity, the allowable costs and expenses under 114.2 CMR 2.06 and 2.08 through 2.11 shall be divided by the larger of a) the provider's actual patient day census or b) 96% of the provider's licensed bed capacity. The allowable costs and expenses under 114.2 CMR 2.07 shall be divided by the provider's licensed bed capacity for the calendar year. The final rate computed under 114.2 CMR 2.04(2) may also be increased by the amount of any *per diem* adjustments pursuant to 114.2 CMR 2.16(7).

(3) Segregated Costs. When the licensed bed capacity is less than the total bed capacity, the final rate shall be based on the segregation of fixed and variable costs. The fixed costs shall be divided by the larger of the provider's actual patient day census or 96% of total bed capacity. The allowable nursing and variable costs and average equity capital shall be divided by the larger of a) the provider's actual patient day census or b) 96% of the provider's licensed bed capacity. For facilities constructed after January 1, 1979, the fixed and variable costs attributable to the first 12 months of operation only will be divided by 96% of the licensed bed capacity or actual patient day census, whichever is greater.

(4) Audits. Costs and expenses to be included in the final rate of payment shall be established on the basis of either a desk audit of the provider's Reports and accompanying materials or an on-site audit of the books and records of the provider and related parties.

(5) Excess Nursing Costs. If a portion of a provider's nursing costs are disallowed under 114.2 CMR 2.08 and the provider receives no disallowance for excess variable costs, the disallowed excess nursing costs may be included up to an amount equal to the difference between the variable cost ceiling established under 114.2 CMR 2.06 and the provider's actual variable costs.

(6) Rate Limitation. No final rate of payment established under 114.2 CMR 2.00 shall exceed the rate charged by the provider to private payers for the same or similar services. When a long-term care provider fails to satisfy this requirement, the Commission shall recoup the difference between the final rate and the rate charged to private patients multiplied by the number of patient days for those discounted private patients. The limitation shall not apply to the portion of a rate established for Patient Protector Receivers appointed pursuant to M.G.L. c. 111, s. 72N which reimburses for the Receiver's compensation and bond as determined in 114.2 CMR 2.16(8).

((7) Reserved)

(8) Payments to Related Parties. Expenses otherwise allowable shall not be included for purposes of determining a final rate under 114.2 CMR 2.00 where such expenses are paid to a related party unless the provider identifies any such related party and expenses attributable to it in the Reports submitted under 114.2 CMR 2.00 and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Commission may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability. Rental and leasehold expenses are further limited under 114.2 CMR 2.06.

(9) Final Settlement. The difference between the interim rates of payment for the calendar year and the final rate of payment shall result in a final settlement between the appropriate governmental unit and each provider. Where a transfer of the facility has occurred, the liability of the transferee and of the transferor for any decrease between the interim and final rates shall be governed by the policies and regulations of the Department of Public Welfare, as amended from time to time. The recording of an asset or liability resulting from a final settlement or from a rate appeal determination under 114.2 CMR 2.15 shall be reflected in the Reports for the year in which the final rate or the appeal rate is certified by the Commission.

2.04: continued

Example: If the Commission in 1988 certifies a final rate for 1986, the accrual resulting from the differential between the final rate and the interim rates for 1986, whether an asset or liability, will be reflected on the books and records of the provider in 1988 and reported on the RSC-1 report for 1988.

The computation of the difference between the interim rates of payment for the calendar year and the final rate of payment as it applies to 114.2 CMR 2.10(1)(a) shall not consider any patient-specific interim or final rates.

(10) Notice of Proposed Rate. At least ten days prior to scheduled Commission action certifying a final rate for a provider, a notice of the proposed rate and a copy of adjustments to the provider's costs shall be sent to the provider. A provider may comment in writing on the proposed rate and adjustments during the period between notice and scheduled Commission action. If additional time is required to formulate a written comment, the provider may request a postponement of scheduled Commission action.

(11) Determination of Reasonable Capital Expenditure for Facilities Building in Urban Underbedded Areas. For the purposes of establishing final rates of payment, special provisions, as defined in 114.2 CMR 2.12(6), will be utilized to determine Maximum Capital Expenditures for facilities exempt from the Department of Public Health Determination of Need process pursuant to its "Guidelines For Determination of Need Exemptions for Long-Term Care Beds Constructed in Urban Underbedded Areas".

2.05: Principles for Establishing Interim Rates of Payment

(1) Interim *Per Diem* Rate. The interim rate of payment effective for the 12-month period beginning October 1 shall be the sum of the elements set out in 114.2 CMR 2.06 through 2.11, each computed for the preceding calendar year on a *per diem* basis with modifications set forth in 114.2 CMR 2.05 except that, for facilities which have changed ownership, the preceding calendar year shall include only the period during which the new owner owned the facility. The interim rate of payment shall be established whenever possible on the basis of on-site audited data; otherwise, the interim rate of payment shall be established on the basis of data which has been the subject of a desk audit. Costs and expenses included in determining a provider's interim rate of payment are subject to all limitations and conditions set forth in 114.2 CMR 2.00 unless specific expectations are set forth in 114.2 CMR 2.05. In the case of multilevel facilities which include resident care units, separate interim *per diem* rates shall be computed for those beds licensed for residential care. No interim rate of payment established under 114.2 CMR 2.05 shall exceed the rate charged by the provider to private party payers for the same or similar services. The extended interim rate effective October 1, 1990 to December 31, 1990 for those facilities which have been designated by the Department of Public Welfare to receive prospective case-mix rates pursuant to 114.2 CMR 5.00, Prospective Rates of Payment to Long-Term Care Facilities, effective January 1, 1991 shall be the interim rate in effect on September 30, 1990.

(2) Cost Adjustment Factors. For long-term care providers, there shall be added in calculating the interim rate a cost adjustment factor which shall be an annually-determined percentage of the allowable costs exclusive of interest, depreciation and legal fees, for the calendar year preceding the effective date of the interim rate. The amount determined by such percentage shall be divided by the larger of a) the provider's actual patient day census or b) 96% of the provider's licensed bed capacity. The cost adjustment factor shall be determined by multiplying the weight of several categories as determined from the submitted reports such as salaries, food, plant expense, medical supplies and other expenses by its corresponding economic change indicator established by Data Resources, Inc. to measure the anticipated changes in costs from the reporting year to rate year. Where there has been a change in ownership in the preceding calendar year and the interim rate has been based upon the new owner's reporting period pursuant to 114.2 CMR 2.05(1), Interim *Per Diem* Rate, the cost adjustment factor shall be modified to reflect the number of months from the midpoint of the reporting period to the midpoint of the interim rate period.

2.05: continued

(3) Computation of the Interim *Per Diem* Rate. When the licensed bed capacity is equal to the total bed capacity, the allowable costs and expenses as reported in the Reports for the preceding calendar year under 114.2 CMR 2.06 and 2.08 through 2.11 as modified in 114.2 CMR 2.00 shall be divided by the larger of a) the provider's actual patient day census or b) 96% of the provider's licensed bed capacity. The allowable costs and expenses under 114.2 CMR 2.07 shall be divided by the provider's licensed bed capacity for the calendar year. The allowance under 114.2 CMR 2.10(1)(a) shall be divided by the publicly-aided patient days.

(4) Segregated Costs. When the licensed bed capacity is less than the total bed capacity, the interim rate shall be based on the segregation of fixed and variable costs. The fixed costs shall be divided by the larger of the provider's actual day census or 96% of total bed capacity. The variable and nursing costs and average equity capital shall be divided by the larger of a) the actual patient day census or b) 96% of the provider's licensed bed capacity. For facilities constructed after January 1, 1979, the fixed and variable costs attributable to the first 12 months of operations only will be divided by 96% of licensed bed capacity or actual patient day census, whichever is greater.

(5) Reasonable Operating Costs. The provisions and limitations set forth in 114.2 CMR 2.06 shall apply for purposes of determining the interim rate of payment for a provider, except that reasonable operating costs shall be based upon the Reports submitted for the preceding calendar year and excluded from such costs shall be variable costs incurred by the provider during said calendar year in excess of one standard deviation above the mean allowable costs incurred by a representative sampling, as determined by the Commission, of providers in the same group. For purposes of this limitation, the computation of one standard deviation above the mean allowable variable costs shall be based on the most recent data compiled by the Commission and shall exclude working capital interest.

(6) Reasonable Nursing Costs. The provisions and limitations set forth in 114.2 CMR 2.08 shall apply for purposes of determining the interim rate for a provider, except that costs shall be based upon the Reports submitted for the second preceding calendar year and excluded from such costs shall be costs incurred by the provider during said calendar year in excess of one standard deviation above the mean costs incurred by a representative sampling, as determined by the Commission, of providers in the same group. For purposes of this limitation, the computation of one standard deviation above the mean costs shall be based on the most recent data compiled by the Commission.

(7) Rate Adjustment for Average Equity Capital. The amount of average equity capital for computation of the interim rate shall be based on the Reports for the second preceding calendar year subject to the definition in 114.2 CMR 2.02 and the limitations on acquisition cost set forth in 114.2 CMR 2.12. The interim *per diem* rate of a proprietary provider which has a positive equity position shall be increased by an annually-determined percentage of the average equity capital divided by the larger of the provider's actual patient day census or 96% or the provider's licensed bed capacity for the calendar year. The annually-determined percentage for the interim rate effective October 1, 1990 shall be approximately 9.80%. This percentage will be updated with the most current available data prior to October 1, 1990.

(8) Accrued Unpaid Expenses. When a provider fails to pay expenses which have been accrued at year end for more than 120 days and which have been included in the interim rate, the Commission may adjust the interim rate downward to reflect only those costs which have been paid.

2.05: continued

(9) Payments to Related Parties. Expenses otherwise allowable shall not be included for purposes of determining an interim rate under 114.2 CMR 2.00 where such expenses are paid to a related party, unless the provider identifies any such related party and expenses attributable to it in the Reports submitted under 114.2 CMR 2.00 and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable service, facilities or supplies that could be purchased elsewhere. The Commission may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability. Rental and leasehold expenses are further limited under 114.2 CMR 2.06.

(10) Rate Limitation.

(a) Private Payor Rate Limitation. No interim rate for a provider established under 114.2 CMR 2.00 shall exceed the lower of the rate charged by the provider to private payors for the same or similar services or accommodations. When a long-term care provider fails to satisfy this requirement, the Commission shall recoup the difference between the interim rate and the rate charged to private patients multiplied by the number of patient days for the discounted private patients.

(b) Outside Budget Limitation Pursuant to St. 1989, c. 240, § 102. No interim rates shall be certified by the Commission to the Secretary of State until such rates have been approved by the Secretary of Administration and Finance. No such rates shall be approved by said Secretary unless the weighted average of rates computed under 114.2 CMR 2.00 and rates computed under 114.2 CMR 5.00 is determined not to exceed the comparable rates for the preceding year by more than the annual increase of the medical care component of the National Consumer Price Index as projected by Data Resources, Inc.

(c) Exceptions to Rate Limitations. No such limitation shall apply to the portion of a rate established for Patient Protector Receivers appointed pursuant to M.G.L. c. 111, § 73, which reimburses for the Receiver's compensation and bond. No such limitation shall apply to the rate of a particular nursing home which otherwise would exceed such limit if the Secretary finds, after consultation with the Commission and the Secretary of Human Services, that a revised rate is required to comply with the provisions of Title XIX of the Social Security Act.

(11) Failure to File Reports.

(a) When a long-term care provider has failed to file the required Reports by May 1, no interim rate shall be calculated until the required reports have been filed. In such cases, an interim rate will be promulgated effective the first day of the sixth month following the receipt of an acceptable cost report.

Example: A provider files the required reports on July 10, 1989. The interim rate based on those reports will be effective January 1, 1990.

(b) The deferral of the effective date shall not apply in cases when the newly-established rate is lower than the prior rate.

(12) Determination of Reasonable Capital Expenditure for Facilities Building in Urban Underbedded Areas. For the purposes of establishing interim rates of payment, special provisions as defined in 114.2 CMR 2.12(6), will be utilized to determine Maximum Capital Expenditures for facilities exempt from the Department of Public Health Determination of Need process pursuant to its "Guidelines For Determination of Need Exemptions for Long-Term Care Beds Constructed in Urban Underbedded Areas".

2.06: Reasonable Operating Costs

(1) Reasonable Operating Costs. Reimbursement for reasonable operating costs based on the provider's Reports shall be allowed, subject to the limitations and conditions set forth in 114.2 CMR 2.06.

2.06: continued

(2) Limitation on Reasonable Operating Costs. There shall be excluded all allowable variable costs in excess of one standard deviation above the mean allowable variable costs incurred by a representative sampling, as determined by the Commission, of providers in the same group. For purposes of 114.2 CMR 2.06(2), variable costs shall not include nursing costs, motor vehicle costs or interest on short-term or working capital loans. Where a group includes less than 15 providers, variable costs in excess of the 84th percentile shall be excluded. These limitations will be determined whenever sufficient data is available to the Commission and at the same time as the computations of efficiency groups established pursuant to 114.2 CMR 2.16(7)(b)2., Acceptable Compliance Incentive.

(3) Groupings for Representative Sampling. For purposes of computing the limitation on reasonable operating costs, providers shall be grouped as follows:

(a) Heavy Case-Mix Intensity Facilities;
(b) Light Case-Mix Intensity Facilities;
(c) Moderate Case-Mix Intensity Facilities;
(d) Facilities or units thereof providing exclusively pediatric care;
(e) Certified long term care nursing units of acute and chronic care hospitals; and
(f) Public Medical Institutions.

Provided, however, that the Health Care Financing Administration allows continued use of the previously approved limitations for a transition period not to extend beyond December 31, 1990, the limitations described above shall not be used in computing the limitation on reasonable variable costs until January 1, 1991. For the period of October 1 through December 31, 1990, facilities shall be reimbursed according to the grouping in effect on September 30, 1990.

((4) Reserved)

(5) Exclusions form Reasonable Operating Costs. The following are examples of exclusions from reasonable operating costs:

(a) Expenses, fees, salaries, or other compensation for the administration or policy planning functions;
(b) Prescribed legend drugs for individual patients;
(c) Bad debts, refunds, charity and courtesy allowances and contractual adjustment to the state and other third parties;
(d) Recovery of expense items, that is, expenses which are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than patients, telephone income and medical records income. Vending machine income shall be recovered against allowable expenses. Laundry income shall not be recovered against expenses unless the provider has failed to identify and exclude all laundry costs which are specially provided to private patients;
(e) Federal and state income taxes (but not the nonincome related portion of the Massachusetts corporate excise tax);
(f) Expenses which are not directly related to the provision of patient care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expense, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
(g) Compensation and fringe benefits for patients or residents on a provider's payroll;
(h) Any amounts in excess of any schedule or limitation contained in 114.2 CMR 2.00;
(i) Costs of ancillary services required by 114.2 CMR 2.00 or by a governmental unit to be billed on a direct basis to the purchasing government unit;
(j) Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;

2.06: continued

(k) Any increase in compensation or fringe benefits which, after a final adjudication by the court of last resort having jurisdiction thereof, is granted as a result of an unfair labor practice;

(l) Accrued expenses which remain unpaid one year after the close of the cost reporting year shall not be included in the final rate. Such costs may be included in the next final rate as an expense, if allowable, if they are paid in the next year;

(m) Exclusions from Reasonable Operating Costs. No individual salary or fee plus payroll taxes, fringe benefits and other increments related to such compensation paid by the provider, or accrued by the provider for the benefit of any person, shall exceed the Administration and Policy Planning Allowance determined for the facility pursuant to 114.2 CMR 2.07(2) except that, in nursing facilities which are licensed for 50 beds or less, this limitation shall not apply to the position of Director of Nurses.

(n) Interest on working capital obligations.

(o) Purchased Service Nursing expenses that are purchased from temporary nursing agencies that are not registered with the Department of Public Health under 105 CMR 157.000.

(6) Exclusions from Reasonable Operating Costs -- Costs of Services Billed Directly.

(a) The following medical supplies or services shall be billed directly to the governmental unit which purchases the service in accordance with the applicable program policies, requirements, and benefit limitations established by the governmental unit responsible for payment at rates governed by the applicable regulations of the Commission, and the costs of such supplies or services shall not be included in rates established under 114.2 CMR 2.00:

1. Direct physician services to individual patients, including emergency physician services required by the Department's Rules and Regulations for the Licensing of Long-Term Care Facilities (1977) or its most recent applicable regulations;
2. Pharmacy costs related to legend drug prescriptions; and
3. Direct restorative services in physical therapy, occupational therapy, and speech or audit therapy, except in the case of facilities or units of facilities providing exclusively pediatric care. Direct restorative services are those which are provided only upon written order of a physician.

(b) The Commission may allow the inclusion of direct medical services or supplies for certified long-term care units of acute and chronic care hospitals in accordance with the regulations or written policy of the governmental unit responsible for paying for such services or supplies in the *per diem* rate where inclusion of such costs are more efficient and practicable for the establishment of fair, reasonable and adequate rates.

(7) Indirect Restorative Therapy Services. Indirect restorative therapy services, such as case conferences or in-service education programs, are reimbursable as reasonable operating costs provided they are documented in a written summary available for inspection in the facility. This summary should be in the form of a consultant book for each discipline and should be updated at least monthly.

(8) Legal Expenses. Only the following legal fees shall be included as reasonable operating costs:

(a) Reasonable and necessary legal fees and expenses directly related to the collective bargaining process subsequent to unionization shall be included as reasonable operating costs.

(b) Reasonable and necessary legal fees and expenses incurred in obtaining a real estate tax abatement shall be included as reasonable operating costs up to a dollar amount not exceeding the savings realized and shall be amortized over the period in which the savings are realized.

(c) Legal fees and expenses directly applicable to the preparation of an actual participation in appeals before the Division of Administrative Law Appeals or litigation before the courts, or other proceedings arising under the provisions of M.G.L. c. 6A, § 36, shall not be reimbursable as legal expenses but shall be treated as Appeal Expenses under 114.2 CMR 2.06(28).

2.06: continued

(9) Accounting and Auditing Expenses. Reasonable and necessary accounting and auditing expenses incurred by a provider in matters directly related to the provision of adequate patient care to publicly-aided patients shall be included as a reasonable operating cost, provided that the books and records of the provider are maintained in accordance with generally-accepted accounting principles, except that accounting fees and expenses directly applicable to the preparation of and actual participation in appeals before the Division of Administrative Law Appeals or litigation before the courts, or other proceedings arising under the provisions of M.G.L. c. 6A, § 36, shall not be reimbursable as accounting expenses but shall be treated as Appeal Expenses under 114.2 CMR 2.06(28).

(10) Education Expenses - Limitation. The net cost of the provider's contribution to the cost of required educational activities of full-time employees shall be included as a reasonable operating cost. Educational activities must be conducted within the Commonwealth of Massachusetts and be directly related to improving patient care to publicly-aided patients and conducted by a recognized school or other authorized organization. The net cost is the cost of required educational activities less any reimbursement from grants, tuition, specific donations, employee contributions, or other sources. Education expenses for Administrators- in-Training shall not be reimbursable. Education expenses for Continuing Education for licensed administrators shall be considered part of the Administration and Policy Planning Allowance.

(11) Educational Expenses - Verification. In order to obtain reimbursement under 114.2 CMR 2.06(10), providers must maintain records of educational expenses which include the names of the schools or other organizations sponsoring the educational activity, the names and positions of employees attending, the date and location of the activity, the number of continuing professional credits earned, if any, and a copy of the outline of subjects covered.

(12) Employment Agency Fees. Expenses paid to employment agencies or consultants for the purpose of recruiting personnel shall be considered part of the Administration and Policy Planning Allowance.

(13) Advertising Expenses. The reasonable and necessary expenses of newspaper or other public media advertisements for the purpose of securing necessary employees shall be included as a reasonable operating cost. No other advertising expenses shall be included as reasonable operating costs.

(14) Generally Available Employee Benefits. To the extent of the provider's contribution, Generally Available Employee Benefits shall be included in reasonable operating costs. To qualify for reimbursement for a Generally Available Employee Benefit, the provider must establish and maintain evidence of its nondiscriminatory nature. Generally Available Employee Benefits shall include group health and life insurance, pension plans, seasonal bonuses and non-required job-related educational benefits. Bonuses related to profit, private occupancy or directly or indirectly to reimbursement rates shall not be reimbursable. Benefits which are related to salaries shall be limited to allowable salaries. Benefits which are related to the administrator shall be considered part of the Administration and Policy Planning Allowance. Required educational and pension benefits shall be reimbursed separately under 114.2 CMR 2.06(10) and 2.06(23), respectively.

(15) Membership Dues. Reasonable and necessary membership dues shall be included as reasonable operating costs so long as the organization's function and purposes are directly related to the development and operation of the provider's facilities and programs and the rendering of adequate patient care. Membership dues shall not include:

(a) Amounts, assessments, accruals or contributions which are for the purpose of directly or indirectly financing or otherwise supporting political or lobbying activities regarding legislation to affect government regulatory activities, or reimbursement methods;

(b) Campaign contributions;

2.06: continued

(c) Advertising to affect legislation or create goodwill or to otherwise affect payments made by governmental units; and

(d) Amounts, assessments, accruals or contributions which are for the purpose of directly or indirectly financing or otherwise supporting litigation regarding government regulatory activities or reimbursement methods.

(16) Rental and Leasehold Expense -- Limitation.

(a) Rental and leasehold expense for land, building and equipment shall be allowed as a reasonable operating cost in the lower amount of average rental or ownership costs of comparable providers or the reasonable and necessary costs including interest, depreciation, real property taxes and insurance of the provider and lessor. In addition, a return on average equity capital may also be allowed to proprietary lessors if it would otherwise have been allowed had the provider owned the facility. For recognition of these expenses and allowances in lieu of rent, the provider must file, or in the case of a lease from a nonrelated party, must arrange for the lessor to file a form RSC-2, Real Property Report.

(b) Providers who rent or lease central office space outside of the facility and can demonstrate that such space contributes to the efficiency of the provider shall have such rent allowed as a reasonable operating cost at the lower of average rental of comparable providers or the lowest rent paid for comparable space at that location. In such instances, a form RSC-2, Real Property Report, need not be filed. In lieu of form RSC-2, the provider shall file a copy of the lease with the Commission together with a statement which describes the rented central office location including the total square footage actually used and necessary for current operations.

(c) Providers who rent or lease incidental office equipment such as typewriters, copying machines or computers shall have such rent allowed as a reasonable operating cost subject to the prudent buyer concept provided that such rental is necessary and it can be demonstrated that it contributes to the efficiency of the provider.

(17) Rent Based on Income. Additional rental payments or charges based upon receipts or income shall not be considered as additional rental expense.

(18) Motor Vehicle Expenses. The costs of operation of any motor vehicle shall be a reasonable operating cost if the vehicle is used directly in the operation of a provider subject to the following limitation: The maximum allowance for each vehicle shall be the greater of an amount equal to $30.00 per bed or $600.00 per provider, but the allowance for all vehicles shall not exceed $1,500.00 per provider. Motor vehicle expenses shall include depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, sales tax, and all other related expenses.

(19) Services of Non-Paid Workers. Subject to 114.2 CMR 2.06(20) the net value of services for non-paid persons in positions customarily held by paid employees, who perform such services on a regular basis as non-paid members of religious or other organizations shall be allowable as an operating expense if otherwise allowable as a reasonable operating cost under 114.2 CMR 2.00. Such services shall be performed under an agreement between the organization and the provider for the performance of the services without direct payment from the provider to the member. The value of services normally provided on a voluntary basis, such as distribution of magazines and newspapers to patients, shall not constitute a reasonable operating cost.

(20) Services of Non-Paid Workers -- Requirement. To qualify as a reasonable operating cost, services of non-paid workers under 114.2 CMR 2.06(19) must meet the following requirements:

(a) The amount allowed shall not exceed that which would be paid others for similar work;

2.06: continued

(b) The amount paid by the provider to the organization must be identifiable in the records of the provider as a legal obligation; and

(c) The services must be performed on a regular, scheduled basis and must be necessary for the provision of adequate patient care to publicly-aided patients and for the efficient operation of the provider.

Example: Assume that the prevailing salary of a registered nurse is $22,000 per year for full-time services. An unpaid worker, as described above, receives maintenance and other benefits equal to a value of $5,000 but no salary. The provider would then include in its records an additional $17,000 to bring the value of the services rendered up to $22,000. The amount of $17,000 would be allowable where the provider assumes an obligation for the $5,000 expense under a written agreement with the organization for payment by the provider for the services.

(21) Administrators-in-Training. Reasonable compensation, including fringe benefits, paid by a provider to no more than two administrators-in-training shall be recognized as a reasonable operating cost in addition to scheduled allowances under 114.2 CMR 2.07, if the provider is licensed by the Department to operate no less than 60 beds, which must include skilled nursing facility beds, and the administrators-in-training are:

(a) enrolled in a training course approved by the Board of Registration of Nursing Home Administrators,

(b) under the direct supervision of a full-time administrator, and

(c) copies of the preceptor's reports are maintained at the facility.

(22) Non-Legend Drugs. The reasonable and necessary costs of providing the non-legend drugs listed in the Department's Circular Letter LTCFP: 1-75-71, as amended by the Department from time to time, including those non-legend drugs which are ordered by a doctor, shall be included as reasonable operating costs and the provisions of these supplies shall not be billed directly to any governmental unit or charged against the personal care funds of any patient.

(23) Pension Plan -- Limit. Reasonable and necessary expenses incurred by a provider relating to a pension plan shall be included as a Generally Available Employee Benefit to the extent that the provider's payments represent an amount based upon fair, reasonable and necessary compensation for services performed by employees. In no event shall reimbursable pension expense cause an individual's total compensation to exceed the limits contained in 114.2 CMR 2.06 (5)(m).

(24) Pension Plans -- Prior Years' Service. Reasonable and necessary expenses incurred by the provider relating to a pension plan shall mean costs incurred on current aggregate year's payroll and shall not include payments for prior year's services.

(25) Pension Plan -- Requirements. A pension plan must provide for either a fixed, determinable amount to be contributed by the employer on a regular basis or for a fixed, determinable benefit to be received by the employee at retirement. Cost generated by any pension plan which does not meet these requirements or which provides that contribution by the provider to the plan is contingent on a profit by the provider or is at the discretion of the management of the facility shall not qualify as a reasonable operating cost. Any forfeiture by an employee must be applied to reduce the premium amount paid by the employer. Every pension plan for which reimbursement is sought shall be filed with the Commission and be subject to periodic review to assure that the plan may be reasonably expected to provide benefits to both professional and non-professional employees, to stabilize the employees' turnover rate in facilities, and to make more attractive employment in said facilities; and that its costs are reasonable and consistent with other such plans.

2.06: continued

(26) Pension Plans -- Approval by Internal Revenue Services. To be reimbursable, a pension plan must have met the current requirements of and received the approval of the Internal Revenue Service. All applicable Internal Revenue Service Forms documenting Internal Revenue approval must accompany the RSC-1 report or be made available to on-site auditors.

(27) Pension Plans -- Required by State Statute. Long-term care providers that are required by enabling statute to make payments to a municipal pension fund shall be reimbursed for the sum of a) the aggregate compensation of the employees covered by the Plan, or for any individual so covered, including any individual who is designated as performing the Administration and Policy Planning function and for whose services the schedule contained in 114.2 CMR 2.07, Administration and Policy Planning Allowance, constitutes the upper limit and b) the imputed value of the employer's cost of participating in the Federal Social Security program.

(28) Appeal Expenses. All fees and expenses including, but not limited to, legal and accounting fees and expenses, directly applicable to the preparation of an actual participation in appeals before the Division of Administrative Law Appeals or litigation before the courts, or other proceedings arising under the provisions of M.G.L. c. 6A, § 36, shall be included as reasonable operating costs subject to the following conditions and limitations:

(a) The fees and expenses excluding filing fees of a hearing before the Division of Administrative Law Appeals shall be included as a reasonable operating cost up to the amount of $1,000 provided the appellant prevails on at least one claim set forth in the bill of complaint. In no event shall the appeal expense exceed the value of the successful claim.

(b) The fees and expenses of judicial review of the Division's final decision in the Superior Court for the County of Suffolk pursuant to M.G.L. c. 6A, § 36 shall be included as a reasonable operating cost up to the amount of $1,000 provided the appellant prevails on at least one claim set forth in the bill of complaint.

(c) The sum of fees and expenses for any one appeal initiated under M.G.L. c. 6A, § 36 shall be included as a reasonable operating cost provided such fees and expenses do not exceed a total of $2,000, and further provided that the appellant prevails on a least one claim raised in the bill of complaint.

(d) Any fees required by the Division of Administrative Law Appeals as a prerequisite to filing an appeal shall not be included as a reasonable operating cost.

2.07: Administration and Policy Planning Allowance

(1) Administration and Policy Planning Allowance. An allowance equal to amounts determined under the appropriate schedule at the end of 114.2 CMR 2.07 for administration and policy planning functions shall be made in lieu of any compensation including payroll taxes, fringe benefits including the cost of continuing education requirements, and any other increments related to such compensation paid to an owner, officer, administrator, assistant administrator, office manager, business manager, controller, or to any person who performs primarily administration and policy planning functions and in lieu of any fees for management companies, management or financial consultants. The allowances set forth in 114.2 CMR 2.07(2) are in lieu of compensation for any other services such as nursing, maintenance, bookkeeping, accounting, etc., performed by the qualified licensed administrator of the facility as listed with the Department. Where a full-time administrator is required to be on the premises during the working day by the Department's applicable regulations, the allowance set forth in 114.2 CMR 2.07(2) shall be substituted for the salary, fringe benefits and any other increments of a person performing the administration function during the working day, whether or not that person is the licensed administrator designated by the provider. The salary and related benefits of the positions, Staff Development Coordinator and Quality Assurance Nurse, shall be reimbursed as variable costs and not included in the Administration and Policy Planning Allowance. For the final rate effective January 1, 1989 and the interim rate effective October 1, 1989, the salary and related benefits of the position,

2.07: continued

Quality Assurance Nurse, shall be claimed as an incentive-based variable cost, and of the position, Staff Development Coordinator, shall be claimed as a non-incentive-based variable cost.

(2) Schedule of Administration and Policy Planning Allowance. Approximately the following schedule of annual allowances shall be imputed into the interim and final rates by dividing the annual allowance by the licensed bed capacity. This schedule shall be used in the interim rate effective October 1, 1990 and in the final rate effective January 1, 1990.

For facilities 10 or less to 30 beds	$22,663
plus $652 for each bed in excess of 10.	
For facilities 31 to 50 beds	$35,003
plus $442 for each bed in excess of 31.	
For facilities 51 to 70 beds	$43,778
plus $291 for each bed in excess of 51.	
For facilities 71 to 119 beds	$49,648
plus $221 for each bed in excess of 71.	
For facilities 120 beds or over	$66,454
plus $177 for each bed in excess of 120.	

The APPA schedule may be updated with the most current available inflation factor prior to October 1, 1990.

2.08: Nursing Costs

(1) Limitation on Allowable Nursing Costs. Unless specifically permitted under the exception for excess nursing costs within 114.2 CMR 2.04 or under the recognition of additional nursing costs within 114.2 CMR 2.08, there shall be excluded all nursing costs including compensation for registered nurses, licensed practical nurses, rehabilitation nursing assistants, nurses' aides, including the payroll taxes and fringe benefits related to such compensation, and purchased service nursing, in excess of one standard deviation above the mean nursing costs for a representative sampling, as determined by the commission, of providers in the same group. Where a group includes less than 15 providers, nursing costs in excess of the 84th percentile shall be excluded. These limitations will be determined whenever sufficient data is available to the commission and at the same time as the computation of efficiency groups established pursuant to 114.2 CMR 2.16(7)(b)2., Acceptable Compliance Incentive. Beginning with the interim rate effective October 1, 1987 and the final rate effective January 1, 1987, the salary and related benefits of the position of Director of Nurses in nursing facilities shall be excluded from the calculations of allowable nursing costs and shall be reimbursed separately.

(2) Groupings for Representative Sampling. For purposes of computing the limitation on allowable nursing costs, providers shall be grouped as follows:

(a) Heavy Case-Mix Intensity Facilities;
(b) Light Case-Mix Intensity Facilities;
(c) Moderate Case-Mix Intensity Facilities;
(d) Facilities or units thereof providing exclusively pediatric care;
(e) Certified long term care nursing units of acute and chronic care hospitals; and
(f) Public Medical Institutions.

Provided, however, that the Health Care Financing Administration allows continued use of the previously approved limitations for a transition period not to extend beyond December 31, 1990, the limitations described above shall not be used in computing the limitation on reasonable nursing costs until January 1, 1991. For the period of October 1 through December 31, 1990, facilities shall be reimbursed according to the grouping in effect on September 30, 1990.

2.08: continued

(3) Recognition of Additional Nursing Costs. Where costs in excess of the limitation are the result of requirements of the Department and such requirements for that provider are supported by written certification by the Department according to its appropriate regulations, the Commission may permit recognition in the rate of the associate additional nursing costs.

2.09: Rate Adjustment for Average Equity Capital.

(1) Rate Adjustment for Average Equity Capital. The *per diem* rate of a proprietary provider which has a positive equity position shall be increased by an annually-determined percentage of the average equity capital divided by a divisor as described in 114.2 CMR 2.04(2), 2.04(3), 2.05(3) and 2.05(4) for the interim rate. For the final rate, the annually- determined percentage shall be calculated by totaling 12 monthly rates for the reporting year, each of which represents a percentage equal to 112% of the average monthly rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. This sum shall be then divided by 12 to obtain the annual percentage. For the purposes of establishing an interim rate, the percentage shall be 112% of the most recent available interest on the special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. For the purposes of the interim rate effective October 1, 1990, the percentage will be approximately 9.80% and will be updated with the most current data available prior to October 1, 1990.

(2) Basis for Computation of Average Equity Capital. Average equity capital shall be based on the amounts reflected in the accounts as described in 114.2 CMR 2.02(4) and reported on a straight-line basis in accordance with 114.2 CMR 2.11(2). Providers who have used other than straight-line methods in the determination of depreciation in prior years and such method has not been reimbursed must submit a reconciliation of ending net worth as reported on December 31 of the prior year with net worth as reported on January 1 of the current year. Any extraordinary fluctuations in average equity capital during the year shall be reported by the provider and shall be weighted in the computation of average equity capital as the Commission deems appropriate. The computation of average equity capital shall not be diminished by long-term debt for which interest has been excluded under the refinancing provision of 114.2 CMR 2.10(l)(b) or long-term loans from owners, officers or related parties under 114.2 CMR 2.10(3). For final rates effective January 1, 1983 and interim rates effective February 1, 1984, average equity capital shall be increased to reflect an equity supplement as defined in 114.2 CMR 2.02. The equity supplement shall not be included in final or interim rates for providers who acquire long-term care facilities on or after January 1, 1983. For final rates effective January 1, 1983 and thereafter, average equity capital shall not be reduced by building depreciation occurring on and after January 1, 1983.

2.10: Interest Expense

(1) Maximum Allowable Interest Expense. Reasonable and necessary interest expense shall be included in the rate as follows:

(a) Interest on Working Capital. Interest on short-term or working capital borrowings shall be excluded from reasonable operating costs. In lieu of these costs, an allowance for financing of current operations shall be imputed into rates. Such allowance shall be based on the monthly net average Medicaid accounts receivable reported in the reporting year multiplied by a percent defined as follows. For the final rate, the percent shall be the weighted monthly average for the year of the prime lending rate of the Bank of Boston. For the interim rate, the percent shall be the most recent available prime lending rate of the Bank of Boston. The *per diem* allowance shall be determined by dividing the total allowance by the publicly-aided patient days. For purposes of 114.2 CMR 2.10, the final rate shall include as accounts receivable the net Medicaid receivables for current and prior years outstanding based on the difference between the interim and final rates up to the date of certification by the Commission. For facilities converting to the prospective payment system, and where this final rate will be the last final rate for the facility, the

2.10: continued

Commission shall also include as accounts receivable the net Medicaid receivables for subsequent years in which the last final rate was outstanding. For the purposes of the interim rate effective October 1, 1988, the prime rate shall be approximately 9%. This rate will be updated with the most current data available prior to October 1, 1988.

Example: When the 1988 final rate is certified on June 15, 1990, the difference between the 1988 interim rates and the 1988 final rate times the 1988 publicly-aided patient days will be considered as accounts receivable from January 1, 1990 to July 14, 1990. The amount of accounts receivable for this period shall be imputed into the calculation of the working capital allowance by the Commission.

The Computation of the difference between the interim rates of payment for the calendar year and the final rate of payment shall not consider any patient-specific interim or final rates.

(b) Interest on Long-Term Debt.

1. Reasonable and necessary interest on allowable long-term debt, supported by a fixed asset which is subject to the limitations set forth in 114.2 CMR 2.12, Limitation of Basis for Depreciation, Interest and Equity, shall be included in the interim and final *per diem* rates. Such interest shall be limited to an annually-determined percentage of simple interest on all outstanding long-term loans weighted by the dollar amount of the funds borrowed. For interim and final rates promulgated pursuant to this regulation, the annually-determined percentage shall be, for allowable long-term debts secured prior to January 1, 1983, the rate as stated in the debt instrument at the time of borrowing; and, for allowable long-term debts secured on and after January 1, 1983, the lower of the rate as stated in the debt instrument at the time of borrowing, or a percentage equal to the monthly rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing occurred plus 3%. In no event shall the rate of interest which the Commission allows exceed 15% *per annum*.

2. Interest payments made pursuant to refinancing shall be allowed when the accumulated principal payments on mortgages secured by allowable fixed assets exceeds the accumulated depreciation allowed by the Commission pursuant to 114.2 CMR 2.11, Depreciation. The maximum rate of interest allowed pursuant to such refinancing shall be the lower of the rate as stated in the debt instrument at the time of borrowing, or a percentage equal to the monthly rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing occurred plus 3%. In no event shall the rate of interest which the Commission allows exceed 15% *per annum*.

3. In cases where the provider's allowable long-term financing becomes payable upon demand, refinancing of the outstanding balance which exceeds the difference between the allowable cost of the fixed assets and the allowable depreciation accumulated thereon shall be allowed at a rate not to exceed 11% *per annum*, or 13% *per annum* in the case of a newly-constructed facility licensed on or after January 1, 1979. The interest allowed on the remaining balance shall be the lower of the rate as stated in the debt instrument at the time of borrowing, or a percentage equal to the monthly rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing occurred plus 3%. In no event shall the rate of interest which the Commission allows exceed 15% *per annum*. In cases where the involuntary financing is for amounts in excess of the amount needed to continue the existing loan and the additional proceeds are used for purposes other than expansion, improvement or the addition of equipment subject to 114.2 CMR 2.12, interest expense on the excess mortgage will not be reimbursed.

(4. Reserved)

5. Except as provided for in 114.2 CMR 2.10(1)(b)2., in cases where the provider voluntarily refinances for purposes other than expansion, improvement or the addition of equipment subject to 114.2 CMR 2.12, the reimbursement of long term interest will be calculated as though the refinancing did not occur.

2.10: continued

6. For facilities purchased or constructed on or after January 1, 1983, reasonable and necessary interest will be reimbursed to the extent that the allowable long-term debt is supported by allowable depreciable assets as defined in 114.2 CMR 2.12.

7. Facilities that have been granted advisory rulings prior to January 1, 1983 which allowed interest reimbursement in excess of 15% will not be subject to the 15% limitation in 114.2 CMR 2.10(1)(b)1., 2., or 3.

(2) Maximum Allowable Interest on Individual Loans. In no case shall the rate include recognition of interest in excess of 18% on any individual loan or obligation.

(3) Loans from Owner, Officer or Related Party. Interest expense shall not include interest on loans to the facility from an owner, officer, or related party.

(4) Interest Income. Interest income shall not be recovered against interest expense.

2.11: Depreciation

(1) Depreciation Allowed. Depreciation of buildings and equipment shall be allowed based on accepted accounting principles using as a basis the lower of the original acquisition cost of the facility, an amount based on a cost per bed for the year of construction of the facility which is set forth in the long-term care facility regulation governing the rate year of the original acquisition, or the principles set forth in 114.2 CMR 2.12(2)(e) if a change of ownership occurs on and after January 1, 1983.

(2) Depreciation -- Methodology. In calculating the allowances for depreciation, the straight-line method shall be used. Fully depreciated assets (assets whose depreciable life has expired) shall be separately identified on RSC-1, 2 and 3 cost reporting forms. Costs of fully depreciated assets and related accumulated depreciation shall be reported as provided for on all cost reports unless such costs and accumulated depreciation have been removed from the provider's books and records. Upon the retirement of equipment, a schedule shall be attached to the cost reporting form indicating the cost of the retired equipment, accumulated depreciation and the accounting entries on the books and records of the facility to record the retirement of the asset(s). Upon the expiration of the useful life of a building, an allowance shall be made in lieu of building depreciation, which shall be equal to the building depreciation previously allowed by the Commission in the last full year of the facility's useful life.

(3) Useful Lives. The useful life of assets for depreciation purposes shall be as follows:

Asset	Life	Yearly Rate
(a) Building.		
Class I or II as classified by the Dept. of Public Safety.	40 yrs.	2.5%
Class III or IV as classified by the Dept. of Public Safety.	33 yrs.	3.33%
A building owned and operated by a political subdivision of the Commonwealth or an authority thereof, construction of which was financed through municipal bonds.	20 yrs.	5.0%
(b) Building Improvements. Building or leasehold improvements made subsequent to the beginning of the final rate year must be prorated over the life of the lease or the balance of the estimated life of the building as determined above, but in no case to exceed the yearly rate of 5%.	Various	up to 5%
(c) Equipment, Furniture and Fixtures.	10 yrs.	10%
(d) Motor Vehicle Equipment.	4 yrs.	25%

2.11: continued

(4) Principal and Interest Payments Recognized. In lieu of the amounts allowed for depreciation pursuant to 114.2 CMR 2.11 and interest pursuant to 114.2 CMR 2.12 and in order to facilitate use of M.G.L. c. 44, § 7, as a means of financing long-term care facility renovations or expansion, the Commission may recognize payments of principal and interest made on behalf of a long-term care facility if all of the following conditions are satisfied:

(a) The facility requesting recognition of principal and interest in lieu of depreciation and interest is owned and operated by a municipality or by a duly constituted municipal authority;

(b) The principal and interest payments are related to the financing, governed by the provisions of M.G.L. c. 44, § 7, of renovations to or expansion of an existing facility;

(c) The amount of principal and interest recognized does not exceed the amount of depreciation and interest that would have been recognized had the provisions of 114.2 CMR 2.10 and 2.11 been applied;

(d) The Commission is satisfied that no reasonable alternative method of financing is available to the facility to generate the funds needed to make the initial principal and interest payment required under M.G.L. c. 44, § 19. No adjustment to an interim rate or calculation of a final rate shall be made under the provisions of 114.2 CMR 2.11 until the municipal bonds used to generate the financing for the renovations or expansion have been duly issued under the provisions of M.G.L. c. 44, § 7. When the Commission has permitted recognition of principal and interest in lieu of depreciation and interest in accordance with 114.2 CMR 2.11 and the proposed renovations or expansion are not completed, or the principal and interest payments required by M.G.L. c. 44, § 19 are not made, the Commission may adjust the rate for the facility to eliminate such allowance and require repayment of amounts previously allowed under 114.2 CMR 2.11(4).

In addition to the above principal payments in lieu of depreciation may also be recognized for facilities that are owned and operated by counties and which have operated as hospitals but have been relicensed as long-term care facilities. In no event shall the bond principal payments, together with any depreciation allowed, if any, exceed the amounts which would have been paid over the useful life of the assets which are financed by the bond.

2.12: Limitation of Basis for Depreciation, Interest and Equity

(1) Application of 114.2 CMR 2.12. The basis for assets established under 114.2 CMR 2.12 shall be uniformly applied to the calculation of allowable depreciation, interest and equity. In no case shall allowable costs for depreciation, interest and equity be calculated on a basis which exceeds the limitations of 114.2 CMR 2.12.

(2) Allowable Basis for Fixed Assets.

(a) Where there has been no change of ownership, the allowable basis of fixed assets shall be the reasonable construction costs.

(b) Where there has been a change of ownership before July 1, 1976, the allowable basis of fixed assets shall be governed by the applicable regulation and shall be the lower of acquisition cost or the allowable dollar amount per bed for building and equipment for the year of construction which is set forth in the long-term care regulation governing the rate year of the change of ownership and beginning in rate year 1974 reduced by the amount of actual depreciation allowed to the immediate prior owner of the facility in calculating rates of payment for publicly-aided patients for the years 1968 to the present.

(c) 1. Where there has been a change of ownership between July 1, 1976 and December 31, 1978, the allowable basis of fixed assets shall be the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment for publicly-aided patients for the years 1968 to the date of the change of ownership. Where the amount of actual depreciation allowed for the facility in a prior year is not known, the new owner shall have the burden of demonstrating the amount, or the amount will be reconstructed by the Commission using the best available information.

2.12: continued

2. Where there has been a change of ownership between July 1, 1976 and December 31, 1978, the allowable basis of fixed assets previously transferred subsequent to January 1, 1968 shall be depreciated over the remaining useful life. Where there has been a change of ownership between July 1, 1976 and December 31, 1978, the allowable basis of fixed assets previously transferred prior to January 1, 1968 shall be depreciated over their remaining useful life plus the number of years the assets were in the possession of the transferor prior to 1968. For any change of ownership between July 1, 1976 and December 31, 1978, the annual amount of depreciation on the assets that have been transferred shall not exceed that allowed to the previous owner.

(d)1. Where there has been a change of ownership between January 1, 1979 and December 31, 1982, the allowable basis of fixed assets shall be:

- For land, the lower of the acquisition cost or the basis allowed the immediate prior owner;
- For equipment, the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment for publicly-aided patients;
- For building and building improvements, the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment to publicly-aided patients for the years 1968 to the date of the change of ownership.

In all transfers where the amount of actual depreciation allowed for the facility in a prior year is not known, the new owner shall have the burden of demonstrating the amount, or the amount will be reconstructed by the Commission using the best available information.

2. Where there has been a change of ownership between January 1, 1979 and December 31, 1982, the allowable basis of fixed assets previously transferred subsequent to January 1, 1968 shall be depreciated over their remaining useful life. Where there has been a change of ownership between January 1, 1979 and December 31, 1982, the allowable basis of building and building improvements (but not equipment) previously transferred prior to January 1, 1968 shall be depreciated over their remaining useful life plus the number of years the assets were in the possession of the transferor prior to 1968. For any change of ownership between January 1, 1979 and December 31, 1982, the annual amount of depreciation on the assets that have been transferred shall not exceed that allowed to the previous owner.

(e) 1. Where there has been a change of ownership on or after January 1, 1983, the allowable basis of fixed assets shall be:

- For land, the lower of the acquisition cost or the basis allowed the immediate prior owner;
- For equipment and building improvements, the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment for publicly-aided patients.
- For building, where the change of ownership occurs in 1983, the allowable basis shall be the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment to publicly-aided patients for the years 1968 through 1980.

Where the change of ownership occurs in 1984, the allowable basis for building shall be the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment to publicly-aided patients for the years 1968 through 1978. Where the change of ownership occurs on or after January 1, 1985, the allowable basis for building shall be the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment to publicly-aided patients for the years 1968 through June 30, 1976.

2.12: continued

In all transfers where the amount of actual depreciation allowed for the facility in a prior year is not known, the new owner shall have the burden of demonstrating the amount, or the amount will be reconstructed by the Commission using the best available information.

2. Where there has been a change of ownership on or after January 1, 1983, the allowable basis of building and building improvements shall be depreciated over the remaining useful life plus the number of years that building depreciation was not recaptured in determining the allowable basis of the new owner. For any change of ownership on or after January 1, 1983, the annual amount of depreciation on the assets that have been transferred shall not exceed that allowed to the previous owner.

(3) Forgiveness of Debt. Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, such forgiveness or reduction of debt shall be retroactively applied to reduce the acquisition cost to the transferee.

(4) Change of Ownership. A change of ownership will be recognized when the following criteria have been met:

(a) The change of ownership did not occur between related parties;

(b) The change of ownership was made for reasonable consideration;

(c) The change of ownership was a bona-fide transfer of all the powers and indicia of ownership;

(d) The change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing; and

(e) In the case of a financing agreement between the transferor and the transferee, the agreement is constructed to effect a complete change of ownership and there is compliance with the terms of such agreement. The Commission reserves the right to evaluate the relationship between the transferor and the transferee and monitor compliance with the agreement to assure a complete change of ownership.

(5) Reasonable Construction Cost.

(a) In the case of a newly constructed facility opening for patient care on or after January 1, 1977 but prior to January 1, 1979, the basis of such assets shall be limited to reasonable, audited construction and equipment costs based upon the minimum standards of the Massachusetts Department of Public Health and the Massachusetts Department of Public Safety. In addition, reasonableness shall be determined by a comparison of construction and equipment costs on a per bed basis of facilities newly licensed within the same year. Land cost which exceeds a ratio of 20 to one shall be excluded from the basis.

(b) In the case of a newly-constructed facility opening for patient care on or after January 1, 1979 or a facility whose existing Determination of Need is amended after January 1, 1979, the allowable basis shall not exceed the cost of construction and equipment approved in accordance with M.G.L. c. 111, § 25C or the minimum standards and requirements of the Massachusetts Department of Public Health and the Massachusetts Department of Public Safety whichever is lower. In the event that the Massachusetts Public Health Council, in connection with a Determination of Need pursuant to M.G.L. c. 111, § 25C, imposes a condition on the Determination of Need, the Commission shall reflect such conditions in the calculation of rates where applicable.

(6) Reasonable Capital Expenditures for Facilities Constructed in Urban Underbedded Areas. Effective May 11, 1989, this provision shall govern the determination of Maximum Capital Expenditure (MCE) for new construction by facilities exempt from the Department of Public Health Determination of Need (DON) pursuant to M.G.L. c. 111, § 25C1/2. The MCE shall be the basis of reimbursement of capital expenditure and related expenses as defined in 114.2 CMR 2.00.

(a) To be eligible for treatment under 114.2 CMR 2.12 (6), an applicant must meet the following requirements:

2.12: continued

1. The facility must be located in an "urban underbedded area" as defined in Department guidelines entitled, "Guidelines For Determination of Need Exemptions for Long-Term Care Beds Constructed In Urban Underbedded Areas".

2. In lieu of an approved Determination of Need application, the applicant must submit an approved application for exemption from the Department of Public Health pursuant to the Department's Guidelines.

3. The applicant must contribute at least 10% of the MCE.

(b) In determining the MCE, the Commission will consider the costs of the following:

1. reasonable construction,
2. land acquisition and development,
3. planning and development,
4. financing, and
5. major movable equipment.

In evaluating the reasonableness of costs, the Commission will utilize the same evaluation methodology applied by the Department's DON program, as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 150.017) or the date on which the construction contract was signed, whichever is earlier. This provision ensures statewide consistency in the evaluation of MCE for the purpose of setting rates, and involves comparison of project costs to those of previously approved projects.

(c) Reasonable construction costs. The Commission will consider the size and cost of the facility as follows:

1. Size. The Commission shall utilize the "General Standards of Construction of Long-Term Care Facilities" (105 CMR 151.000), issued by the Division of Health Care Quality, as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 150.017) or the date on which the construction contract was signed, whichever is earlier, to determine the reasonableness of size. These standards represent minimum requirements, which may be adjusted consistent with the standards applied by the Department's DON program as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 150.017) or the date on which the construction contract was signed, whichever is earlier. For the purpose of establishing reasonable construction costs, the Commission will utilize reasonable gross square footage (gsf) in its cost per gsf formula, and will disallow costs associated with gsf which exceed the guidelines for reasonableness.

2. Costs. The following four costs will be included in evaluating costs per gsf:
the site survey,
the construction contract,
Architectural and engineering, and
fixed equipment not in the construction contract.

3. Evaluation methodology. The Commission will utilize the reasonable gsf defined in 114.2 CMR 2.12(6)(c)1. as the divisor for the total costs defined in 114.2 CMR 2.12(6)(c)2. to arrive at the facility's requested gsf costs. This will be compared to the Department's DON standard for reasonable gsf costs as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 105.017) or the date on which the construction contract was signed, whichever is earlier. Costs which exceed this standard will be disallowed as follows:

Example: If the reasonable gsf defined in 114.2 CMR 2.12(6)(c)1. were 40,000, and the total cost defined in 114.2 CMR 2.12(6)(c)2. were $5 million, then the facility's requested cost/gsf is $125. If the reasonable cost/gsf is $90, then $1,400,000 of the total cost will be disallowed. The reasonable construction cost which the facility's rate will be based on is $3,600,000.

(d) Land Acquisition and Development Costs. Allowable costs will be established per 114.2 CMR 2.12(5).

2.12: continued

(e) Allowable Planning and Development Costs. These include the costs of preparing the application for exemption, the financial analysis, legal fees related to articles of organization and purchase and sale and architectural line drawings. The total will be limited to the standard defined by the DON program as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 150.017) or the date on which the construction contract was signed, whichever is earlier. Extenuating circumstances will be treated consistently with the policies applied by the DON program.

(f) Allowable financing costs. The base on which net interest expense will be allowed is no more than ½ of the total reasonable costs of construction, as defined in 114.2 CMR 2.12(c), (d), (e) and (g) The maximum time period for the accrual of interest expense shall be no longer than fourteen months, marked by the date on which the construction contract was signed. The cost of securing financing shall include expenses related to title searches, application fees, and points, as established by the DON methodology as in effect 180 days after final date on which the construction plans were approved by the Department (per 105 CMR 150.017) or the date of on which the construction contract was signed, whichever is earlier.

(g) Major Movable Equipment. The allowable cost of major movable equipment shall be no greater than the maximum set by the Department's DON program as in effect 180 days after final construction plans were approved by the Department (per 105 CMR 150.017) or the date on which the construction contract was signed, whichever is earlier. A provider may submit preliminary MCE costs to the Commission upon receipt of an approved exemption from DON. These preliminary costs will be evaluated for reasonableness in accordance with 114.2 CMR 2.12(6) and per the DON program methodology in effect the date the preliminary MCE schedule was filed with the Commission. These preliminary costs will be considered the preliminary MCE for the purposes of 114.2 CMR 2.04(11) and 2.05(12). A provider may submit updated MCE costs for the purposes of 114.2 CMR 2.04(11) and 2.05(12). These will be evaluated according to the DON program methodology as in effect 180 days after final construction plans were approved by the Department or the date on which the construction contract was signed, whichever is earlier. The preliminary allowable MCE costs, inflated per DON program guidelines in effect the date the preliminary MCE schedule was filed with the Commission, will be compared with the updated allowable MCE costs, and the greater of the two will be considered the allowable MCE. In either case, if actual expenditures are less than those allowed in the MCE schedules, actual expenditures will be used for establishing rates in accordance with 114.2 CMR 2.04 and 2.05.

(7) Repossession by Transferor. Where the transferor repossesses a facility to satisfy the transferee's purchase obligations in whole or in part or becomes directly or indirectly an owner or receives an interest in the transferee's facility or company, the basis of fixed assets will be recomputed. The recomputed basis shall not exceed the transferor's original allowable basis under Commission regulations applicable at the date of change of ownership increased by any allowable capital improvements made by the transferee since acquisition and reduced by depreciation since acquisition.

2.13: New Facilities and Major Additions

(1) Special Interim Rate.

(a) New facilities and additions which have less than six months' cost experience shall be assigned an interim rate of payment based upon a budgetary analysis or reasonable anticipated operating costs and reasonable anticipated publicly-aided patient days insofar as practicable. The principles concerning the allowability of costs contained in 114.2 CMR 2.00 shall be applied to the extent practicable. The special interim rate shall not include a cost adjustment factor. The nursing and variable costs shall not exceed a limitation which shall be established by multiplying ½ of one standard deviation above the mean variable and nursing costs of the facility's allowed licensed beds group of the prior year times the cost adjustment factor established in 114.2 CMR 2.05(2), Cost Adjustment Factor. Such cost adjustment factor will be prorated to make the prior year limitations comparable with the projected period.

2.13: continued

(b) Facilities which have recent cost experience as a health care facility, such as chronic hospitals which have been reclassified as long-term care facilities, may have a special interim rate computed on the latest available cost data but excluding costs which are not appropriate for long-term care facilities such as laboratories of X-ray departments. Such special interim rates shall be subject to 114.2 CMR 2.06(2), Limitation on Reasonable Operating Costs and 114.2 CMR 2.08(1), Limitation on Allowable Nursing Costs.

(2) Reconsideration of Special Interim Rate. After six months of operation, the Commission shall reconsider the interim rate of payment based on the reasonable cost of providing patient care for publicly-aided patients for the relevant period as established in accordance with 114.2 CMR 2.00.

2.14: Petitions for Adjustment to Interim Rates of Payment

(1) Adjustment to Interim Rates of Payment. In addition to other grounds for adjusting an interim rate specified in 114.2 CMR 2.00, the Commission may consider a petition by a provider for an adjustment of an interim rate of payment for any of the reasons set forth in 114.2 CMR 2.14. Processing of petitions shall be suspended for any provider that has failed to comply with 114.2 CMR 2.03, Required Report. If after notification of suspension, the provider fails to file the Required Reports or other information which the Commission may require within 60 days, the petition shall be dismissed.

(2) Substantial Capital Expenditures. A petition for an administrative adjustment may be made if the provider expects, and presents satisfactory evidence of a commitment to incur a substantial capital expenditure; or expects, and presents satisfactory evidence of a commitment to make substantial change in service during the rate year. A substantial capital expenditure is defined as that which costs more than three times the allowable depreciation of a building and improvements in the base year. A substantial equipment purchase is defined as that which costs more than three times the allowable depreciation of equipment in the base year. The change in interest expense associated with substantial capital expenditures, substantial equipment purchase, or the purchase of a facility, also qualifies for an adjustment to the interim rate of payment. Where the capital expenditure is subject to a Determination of Need by the Department under M.G.L. c. 111, §§ 25B to 25G inclusive, an administrative adjustment under 114.2 CMR 2.14 shall be made only after the Department has determined that need exists for the project proposed by the applicant, and after either the time for making an appeal with respect to such determination to the Health Facilities Appeals Board, established under M.G.L. c. 6, § 166, has expired or all administrative and judicial review of such determination have been concluded. An administrative adjustment, however, may be made prior to the Determination of Need with the approval of the Commissioner of Public Health. Upon request of the Commissioner of Public Health, the Rate Setting Commission may determine the appropriate amount of any adjustment before a Determination of Need is made with respect to the expenditure or change proposed by the applicant.

(3) Governmental Requirements. A petition for adjustment to an interim rate of payment may be made where the petitioner has incurred or presents satisfactory evidence of a commitment to incur costs necessary to satisfy requirements of the Department or any other governmental unit relative to the safety of patients, the quality of service provided by such provider, reduction in license quota, or the fiscal operations of such provider. Any application under 114.2 CMR 2.14(3) shall be accompanied by written certification or a copy of an official notice from the Department or other governmental unit detailing the additional requirements imposed on the provider and specifying the statutory regulatory authority under which such requirements are imposed. The submission of copies of Department of Public Health deficiency reports or copies of consent decrees fail to meet the official notice requirement. The official notice shall be a letter from the Department to the Commission which specifically addresses an additional requirement.

2.14: continued

(4) Certain increases in Reasonable Operating Costs. A petition for adjustment to an interim rate of payment may be made when increases in reasonable operating costs have occurred in the following circumstances:

(a) when the provider can demonstrate and document significant and measurable changes in the intensity of patient care and the increased costs of such changes are identifiable to the satisfaction of the Commission. Providers that qualify under 114.2 CMR 2.14 must continue to keep records of intensity of patient care and shall notify the Commission if there is a reversal of the measurements which gave rise to the petition.

(b) when unusual and unforeseen increases in reasonable operating costs, which are not reflected in the interim rate, have occurred to such a degree that the financial stability of the provider is gravely threatened. Examples of such unusual and unforeseen circumstances are loss of licensed beds, events of catastrophic nature, i.e. fire, flood, and real estate tax increases. In measuring the degree to which the financial stability of the provider is gravely threatened, the Commission will consider all of the provider's expenditures.

(5) Other Allowable Changes. Other Allowable Changes to the rate include:

(a) Reimbursement of a Patient Protector Receiver appointed under M.G.L. c. 111, § 72N; and

(b) Reimbursement for Innovative and Special Programs.

(6) Requirements for Petition. A petition under 114.2 CMR 2.14 shall include the following:

(a) The provider's name, address and the rate assigned by the Commission;

(b) A certified statement that such petition is not interposed for delay;

(c) A detailed explanation, under oath, of the basis upon which said increase is sought;

(d) A sworn statement of an independent licensed accountant or independent certified public accountant that he has examined the pertinent data relative to the accounts forming the basis of the petition and that, in his opinion, the accounts are as represented by the petitioner. The Commission may require that such pertinent data be submitted on forms prepared by the Commission.

(7) Sufficient Information. Any petition under 114.2 CMR 2.14 shall contain sufficient information to permit the Commission to translate the expenditure giving rise to the petition and any related project proposed by the petitioner into reimbursable operating and non-operating costs. The petitioner shall provide any other information which the Commission reasonably requires. If the petitioner fails to provide information requested by the Commission within 30 days of such request, the petition shall be dismissed.

(8) Burden of Justification. Petitioners under 114.2 CMR 2.14 shall have the burden of providing adequate information to the Commission to justify an adjustment.

(9) Adjustment Limited. Any adjustment made under 114.2 CMR 2.14 shall be valid only with respect to the incident specified and described in the petition.

(10) Standards of Review. All petitions under 114.2 CMR 2.14 will be considered under the following standards:

(a) Whether the interim rate reasonably approximates the anticipated final rate;

(b) The reasonable costs of other providers offering the same or a comparable level of care; and

(c) Consistency of cost increases whether for wages or other cost levels during the period.

(d) The collectibility of overpayments by the Department of Public Welfare.

2.14: continued

(11) Recommendation of Director of Bureau of Long-Term Care Facilities. In considering action on a petition under 114.2 CMR 2.14(11) the Director of the Bureau of Long-Term Care Facilities shall report in writing his recommendations to the Commission and to the petitioner, stating his reasons in detail. The petitioner shall have ten days to file with the Commission objections, arguments and comments concerning the recommendations of the Director.

(12) Effective Date. Any rate determination resulting from a petition under 114.2 CMR 2.14 shall be effective upon its filing with the State Secretary as of a date which the Commission finds best suited to reflect appropriate reimbursement for any additional financial commitments incurred by the petitioner as a result of the incident giving rise to the petition and any related project proposed by the petitioner.

(13) No Appeal. Commission action on petitions under 114.2 CMR 2.14 shall not be subject to appeal under 114.2 CMR 2.15.

(14) Reviews. 90 days subsequent to the granting of an administrative rate adjustment, the Commission may require that the provider demonstrate that the increases in costs have actually occurred. If the provider fails to provide evidence of such costs within 45 days of the Commission request, the Commission may retroactively reverse the adjustment.

2.15: Appeals

(1) Appeals. Any provider aggrieved by a rate of payment established pursuant to 114.2 CMR 2.00 may file an appeal with the Division of Hearing Officers, established under M.G.L. c. 7, § 4H, within 30 days of the filing of any such rate with the State Secretary. Appeals hereunder shall be governed by the provisions of M.G.L. c 6A, § 36 and by 114 CMR .

(2) Standard on Appeal. On appeal, the validity of any rate established for a provider shall be judged solely on the basis of its conformity with the principles governing the determination of rates contained in 114.2 CMR 2.00.

(3) Pending Appeal. The pendency of a proceeding or hearing may not be construed to prevent the Commission from redetermining a rate of payment for any reason the Commission may consider appropriate under M.G.L. c. 6A, §§ 31 through 46.

2.16: Special Provisions

(1) Mechanical Errors. Where an error has been made in computing a provider's rate under 114.2 CMR 2.00 and the error is the result of a purely mechanical error by the Commission, the Commission shall recompute and recertify a rate under the following circumstances:

(a) Interim Rate - where the error is greater than $750.00 in publicly-aided reimbursement and the provider notifies the Commission in writing of the error within 30 days of filing of the interim rate with the State Secretary.

(b) Final Rate - where the error results in a change in the final rate.

(2) Rates for Innovative and Special Programs. A rate may be calculated to reflect an appropriate allowance for costs and expenses incurred by a provider in establishing and maintaining an innovative program for providing care to publicly-aided patients in any of the following cases:

(a) Where the provider has received prior written approval from the Department of Elder Affairs to establish and maintain a program;

(b) Where the provider is participating in a special program established in connection with the Medical Assistance Division of the Department of Public Welfare under which specific homes may contract to accept patients designated by the agency;

2.16: continued

(c) Where a provider develops and implements on a experimental basis innovative incentive reimbursement systems. Any reimbursement system under 114.2 CMR 2.16(2)(c) must be consistent with the standards of the Department and cannot be initiated without prior written approval from the Commission.

(3) Waiver of Occupancy Requirement for Facilities that are Closing or Converting to Residential Care. For facilities in the process of closing which are identified by the Department of Public Welfare in writing for treatment under this provision, the percentage of occupancy used as a divisor for costs under 114.2 CMR 2.06 and 2.08 through 2.11 shall be equal to actual occupancy for a period not to exceed six months after the official notice of the facility's intention to close is received by the Department of Public Welfare. Beginning March 1, 1983, for long-term care facilities in the process of closing which are identified by the Department of Public Welfare in writing under this provision, the percentage of occupancy used as a divisor for the Administration and Policy Planning Allowance in 114.2 CMR 2.07 shall be equal to the actual occupancy for a period not to exceed six months after the official notice of facility's intention to close is received from the Department of Public Welfare. Rates computed under 114.2 CMR 2.16 will not be subject to the limitations of 114.2 CMR 2.05(5), Reasonable Operating Costs, 114.2 CMR 2.05(6), Reasonable Nursing Costs, 114.2 CMR 2.05(10), Rate Limitation, 114.2 CMR 2.06(2), Limitation on Reasonable Operating Costs, 114.2 CMR 2.08(1), Limitation on Allowable Nursing Costs, or 114.2 CMR 2.04(6), Rate Limitation. For facilities converting to residential care which are identified by the Department of Public Welfare in writing for treatment under this provision, the percentage of occupancy used as a divisor for costs under 114.2 CMR 2.06 and 2.08 through 2.11 shall be the greater of 80% or actual patient days during the conversion process. In identifying facilities for treatment under 114.2 CMR 2.00, the Department of Public Welfare shall supply the Commission with:

(a) the date the facility initiates the closing or conversion process;
(b) the date the facility was granted temporary certification, if applicable;
(c) the date the facility was granted temporary certification or transfer of the last nursing home patient; and
(d) complete census information during the period of the closing or conversion process.

((4) Reserved)

(5) Information Bulletins. The Commission may, from time to time, issue information bulletins interpreting or clarifying provisions of 114.2 CMR 2.00. Such bulletins shall be deemed to be incorporated in 114.2 CMR 2.00, shall be filed with the State Secretary, shall be distributed to providers, rates for which are determined under 114.2 CMR 2.00 and shall be accessible to the public at the Commission's offices during Commission business hours.

(6) Publicly-Aided Patients in Long-Term Care Facilities in States Other than Massachusetts. When a publicly-aided patient is placed in a long-term care facility in a state other than Massachusetts, the Commission shall certify the per diem rate paid by the state in which the facility is located.

(7) Incentives. The Commission may offer financial incentives to eligible providers to encourage the upgrading and maintenance of quality of care in long-term care facilities, to provide for growth and improvements to facilities, and to enhance the financial stability of facilities in order to ensure continuity of care. Provided, however, that the Health Care Financing Administration allows continued use of the previously approved incentives for a transition period not to extend beyond December 31, 1990, the incentives described below shall not be used in computing the incentives on reasonable variable costs until January 1, 1991. For the period of October 1 through December 31, 1990, facilities shall be reimbursed according to the grouping in effect on September 30, 1990.

2.16: continued

(a) Outstanding Compliance Incentive.

1. An adjustment to the final *per diem* rate based upon the data from the reporting year shall be made for providers who meet the following criteria:

i. qualify for the outstanding regulatory compliance group established by the Department pursuant to its regulations;

ii. has nursing and variable costs which have not been subjected to adjustment under 114.2 CMR 2.06(2) and 114.2 CMR 2.08(1).

2. The *per diem* adjustments for qualifying facilities shall be as follows:

Light Case-Mix Intensity: $0.40
Heavy Case-Mix Intensity: $0.60
Moderate Case-Mix Intensity: $0.50

3. No adjustment will be given under 114.2 CMR 2.16(7)(a), Outstanding Compliance Incentive, unless the facility also qualifies under 114.2 CMR 2.16(7)(b), Acceptable Compliance Incentive.

(b) Acceptable Compliance Incentive.

1. An adjustment to the final *per diem* rate, based upon data from the reporting year, shall be made for providers who meet all of the following criteria:

i. maintenance of a level of occupancy of 96% of licensed bed capacity or greater;

ii. qualified for the acceptable regulatory compliance group established by the Department pursuant to its regulations, and also attained a compliance score of 85 or greater;

iii. has nursing and variable costs which have not been subjected to adjustment under 114.2 CMR 2.06(2) and 114.2 CMR 2.08(1); and

iv. maintenance of a level of public occupancy of at least 77% of patient day census.

v. filing of all Cost Reports and Wage Surveys in a timely manner, as described in 114.2 CMR 2.03(1) and 2.03(2).

2. In no case shall the adjustment exceed the difference between the provider's combined nursing and variable cost ceiling and its allowable combined nursing and variable costs.

3. Facilities will be grouped and adjustment will be made according to the facility's combined nursing and variable costs in relation to the mean combined nursing and variable costs incurred by a representative sampling, as determined by the Commission, of providers in the same group which shall be as follows:

Group I - Combined nursing and variable *per diem* costs which are greater than ½ of one standard deviation above the mean costs, but less than one standard deviation above the mean costs.

Group II - Combined nursing and variable *per diem* costs which are greater than the mean costs but equal to or less than ½ of one standard deviation above the mean costs.

Group III - Combined nursing and variable *per diem* costs which are equal to or less than the mean costs but greater than ½ of one standard deviation below the mean costs.

Group IV - Combined nursing and variable *per diem* costs that are equal to or less than ½ of one standard deviation below the mean costs. The combined nursing and variable cost groups shall be established at the same time as the computation of the Limitation on Reasonable Operating Costs pursuant to 114.2 CMR 2.06(2) and the Limitation on Allowable Nursing Costs pursuant to 114.2 CMR 2.08(1). Providers will not be assigned to new efficiency groups after these computations are made.

4. Providers receiving adjustment under 114.2 CMR 2.16(7)(b) may be eligible to receive an adjustment under 114.2 CMR 2.16(7)(a).

5. *Per Diem* rate adjustments under this division are as follows:

2.16: continued

Light Case-mix Intensity Facilities
Efficiency Groups

% Total Occupancy	I	II	III	IV	% Public Occupancy
96				.19	77-84
			.19	.38	85-89
		.19	.38	.56	90-94
	.19	.38	.56	.75	95-100
97	.11	.19	.34	.41	77-84
	.19	.34	.49	.56	85-89
	.34	.49	.64	.79	90-94
	.49	.64	.79	1.01	95-100
98	.15	.26	.49	.56	77-84
	.26	.41	.64	.71	85-89
	.41	.56	.79	.94	90-94
	.56	.79	.94	1.16	95-100
99	.19	.34	.59	.64	77-84
	.34	.49	.74	.86	85-89
	.49	.64	.86	1.09	90-94
	.64	.86	1.09	1.31	95-100
100	.26	.49	.64	.86	77-84
	.41	.64	.86	1.01	85-89
	.56	.86	1.09	1.24	90-94
	.71	1.01	1.24	1.46	95-100

Moderate Case-mix Intensity Facilities
Efficiency Groups

% Total Occupancy	I	II	III	IV	% Public Occupancy
96%				$0.22	77-84
			$0.22	$0.44	85-89
		$0.22	$0.44	$0.66	90-94
	$0.22	$0.44	$0.66	$0.88	95-100
97%	$0.13	$0.22	$0.40	$0.48	77-84
	$0.22	$0.40	$0.57	$0.66	85-89
	$0.40	$0.57	$0.74	$0.92	90-94
	$0.57	$0.74	$0.92	$1.18	95-100
98%	$0.17	$0.30	$0.57	$0.66	77-84

$0.30	$0.48	$0.74	$0.83	85-89
$0.48	$0.66	$0.92	$1.09	90-94
$0.66	$0.92	$1.09	$1.35	95-100

2.16: continued

% Total Occupancy	I	II	III	IV	% Public Occupancy
99%	$0.20	$0.40	$0.67	$0.74	77-84
	$0.40	$0.57	$0.84	$1.00	85-89
	$0.57	$0.74	$1.00	$1.27	90-94
	$0.74	$1.00	$1.27	$1.53	95-100
100%	$0.26	$0.49	$0.64	$0.86	77-84
	$0.41	$0.64	$0.86	$1.01	85-89
	$0.56	$0.86	$1.09	$1.24	90-94
	$0.71	$1.01	$1.24	$1.46	95-100

Heavy Case-mix Intensity Facilities
Efficiency Groups

% Total Occupancy	I	II	III	IV	% Public Occupancy
96%				$0.25	77-84
			$0.25	$0.50	85-89
		$0.25	$0.50	$0.75	90-94
	$0.25	$0.50	$0.75	$1.00	95-100
97%	$0.15	$0.25	$0.45	$0.55	77-84
	$0.25	$0.45	$0.65	$0.75	85-89
	$0.45	$0.65	$0.85	$1.05	90-94
	$0.65	$0.85	$1.05	$1.35	95-100
98%	$0.20	$0.35	$0.65	$0.75	77-84
	$0.35	$0.55	$0.85	$0.95	85-89
	$0.55	$0.75	$1.05	$1.25	90-94
	$0.75	$1.05	$1.25	$1.55	95-100
99%	$0.20	$0.45	$0.75	$0.85	77-84
	$0.45	$0.65	$0.95	$1.15	85-89
	$0.65	$0.85	$1.15	$1.45	90-94
	$0.85	$1.15	$1.45	$1.75	95-100
100%	$0.35	$0.65	$0.85	$1.15	77-84
	$0.55	$0.85	$1.15	$1.35	85-89
	$0.75	$1.15	$1.45	$1.65	90-94
	$0.95	$1.35	$1.65	$1.95	95-100

Example 1: A heavy case-mix care facility which reports overall occupancy of 97% public occupancy of 86% and is grouped for efficiency pursuant to 114.2 CMR 2.16(7)(b)2. in Group II would receive a *per diem* adjustment of $0.34 per day.

2.16: continued

(8) Reimbursement of a Receiver Appointed Under M.G.L. c. 111, § 72N. The interim and final rates of a facility will be increased by an appropriate *per diem* amount to provide reasonable compensation to a receiver appointed under M.G.L. c. 111, § 72N and for payment of this bond. Such compensation and bond expense shall be added to the interim and final *per diem* rates by a formula which shall allow the receiver to obtain reimbursement by the process of billing the Medicaid program by the number of publicly-aided patient days. For example, if the reasonable compensation for a receiver and his bond expense is $5,000 and the facility has provided 2,000 publicly-aided patient days for a 30-day period, the *per diem* add-on under 114.2 CMR 2.16 shall be $2.50 ($5,000 divided by 2,000). Reasonable compensation and bond expense shall be recognized to the extent that the receiver submits detailed invoices which, among other things, include an accounting of hours expended, a brief description of each activity and the hourly rate. The Commission reserves the right to limit the allowable cost to that which is reasonable and necessary to safeguard the health, safety and continuity of care to residents and to protect them from adverse health effects and increased risk of death caused by abrupt or unsuitable transfer. In addition to the above limitation, reasonable Compensation for a receiver and his bond expense shall not exceed $10,000 for the first 30 days, $7,500 for the second 30 days, $2,500 for the third 30 days and $1,500 for each 30 day period thereafter. Expenses unique to the duties of the receiver which are discharged pursuant to M.G.L. c. 111, § 72N, shall be included as reasonable compensation as determined by 114.2 CMR 2.16(8). Other expenses will be considered part of the normal operating costs of the facility and subject to the limitations set forth in 114.2 CMR 2.06(2). In addition, if due to unique circumstances which were certified to by the Department of Public Health and Department of Public Welfare, the Commission may, in its discretion, allow additional compensation for a period not to exceed 90 days.

2.17: Life Safety and Physical Environment Code -- Correction of Deficiencies

(1) Life Safety and Physical Environment Code. In the case of building improvements made solely to satisfy federal requirements under 42 U.S.C. s. 1396(a)(28), 1396d(c) to qualify for participation in the program established under Title XIX of the Federal Social Security Act (Medicaid), the costs associated with the improvements shall be depreciated at a rate of 10% *per annum*. Work performed under 114.2 CMR 2.17 on or after January 1, 1979 shall be depreciated at a rate of 20% *per annum*. The following provisions shall apply to Life Safety improvements made under 114.2 CMR 2.17.

(a) Costs estimates from at least three bidding contractors must be submitted to the Department. Costs for correcting life safety and/or physical environment deficiencies must be itemized on a line by line item basis by deficiency in accordance with the approved Plan of Correction, to the extent reasonable and practicable. The Department may waive the submission of three bids and approve the cost of corrections using actual costs submitted to it by the facility where it deems such waiver reasonable and practical on the basis of the facts and circumstances of each case.

(b) Only those costs related to correction of life safety and/or physical environment deficiencies which are submitted by the provider in its Plan of Correction and approved as reasonable by the Department will qualify for the accelerated useful life provided for in 114.2 CMR 2.17 and only those costs should be reflected in account 16211 Life Safety Costs in the RSC-1 cost report. A contingency factor of up to 10% of the approved costs will be allowed for cost overruns.

(c) Where a facility expands to maintain its licensed number of beds for the sole purpose of curing life safety and/or physical environment deficiencies, the costs associated with physical expansion will qualify for the accelerated useful life provided for in 114.2 CMR 2.17 if the Department has determined that it is more cost effective to expand to maintain licensed beds than to cure the deficiencies within the confines of the existing facility, provided that qualifying facility expansion costs may not exceed the amount specified as follows:

1. The lower of $50 per square foot or $6,500 per bed if Class IV construction is authorized and not prohibited by any statute, or state or federal regulation, otherwise

2.17: continued

2. The lower of $65 per square foot or $8,500 per bed if Class II construction is required by any statute, or state or federal regulation. Cost incurred in excess of the limitations set forth in 114.2 CMR 2.17(1)(c) will qualify for depreciation at the rate specified for building in 114.2 CMR 2.11.

(d) Where a provider receives approval from the Department for an increase in its licensed number of beds and such increase is effected simultaneously with a correction of deficiencies, only those costs which are associated with correction of deficiencies will be depreciated on a ten year life. Expansion to increase the licensed number of beds will be considered as a new facility and will be depreciated at the rate specified for building in 114.2 CMR 2.11.

(2) No reimbursement will be calculated under 114.2 CMR 2.17 unless the provider supports its request with completed RSC-10.

(3) Work performed under 114.2 CMR 2.17 after December 31, 1983 will be depreciated at the rate of 5% *per annum* except for facilities that have otherwise qualified for accelerated depreciation and have initiated major construction prior to January 1, 1984. In such cases, major construction shall be evidenced by substantial work-in-progress reported on the Reports as of December 31, 1983. In no event shall accelerated depreciation be allowed for work not completed by December 31, 1984.

2.18: Rate Filings

(1) Interim rates of payment for long-term care facilities approved under 114.2 CMR 2.00 shall be filed with the Secretary of the Commonwealth under 114.2 CMR 2.18(1).

(2) Final rates of payment for long-term care facilities approved under 114.2 CMR 2.00 shall be filed with the Secretary of the Commonwealth under 114.2 CMR 2.18(2).

2.19: Use and Occupancy Allowance for Certain Nonprofit Providers

The *per diem* rate of nonprofit providers, except those owned or operated by the governmental bodies, shall be increased to reflect the cost of use and occupancy of net allowable fixed assets. Such use and occupancy *per diem* allowance shall be calculated by the formula and method expressed in 114.2 CMR 2.09, Rate Adjustment for Average Equity Capital, and divided by three. This allowance will be added to the *per diem* rates of otherwise eligible nonprofit providers provided that they meet the following criteria: have maintained a public occupancy of 77%.

2.20: Petitions to Increase the Interim Rate Pursuant to St. 1986, c. 279

A provider may file one petition for an increase in the interim rate beginning October 1, 1986 or later, based on 114.2 CMR 2.20 and on St. 1986, c. 279. Such adjustments will be made for facilities that qualify according to the following criteria:

(1) The facility must demonstrate that, as of the date of the petition, more than 75% of its patient population is receiving benefits under M.G.L. c. 118E, the Medical Assistance Program.

(2) The facility must submit a listing of the actual wages paid to nurses' aides, laundry, dietary and housekeeping personnel, whether full or part-time. The wages reported for such personnel shall reflect payments made as of the latest pay period ending before the date of the petition. The facility must file a copy of the payroll summary for the most recent pay period for these employees.

2.20: continued

(3) An adjustment of 6% of the qualifying wages as defined in 114.2 CMR 2.20(2) will be added to the interim rate beginning October 1, 1986 or a later date pursuant to 114.2 CMR 2.20(8).

(4) The adjustment of 6% of the qualifying wages will be added to the interim rate of payment, expressed in terms of *per diem*, by dividing the adjustment by the greater of actual patient days, or 96% of licensed bed capacity, for the pay period. As in all other rate computations, private reservation days and publicly-assisted furlough days must be included in the computation of the actual patient days.

(5) This adjustment will be made to the interim rate notwithstanding any ceilings or caps. However, in calculating final rates pursuant to 114.2 CMR 2.04, the Commission will apply all caps, ceilings and limitations as set forth in 114.2 CMR 2.04(6), Rate Limitation, 114.2 CMR 2.06(2), Limitation on Reasonable Operating Costs, 114.2 CMR 2.06(5), Exclusion from Reasonable Operating Costs, 114.2 CMR 2.08(1), Limitation on Allowable Nursing Costs, and the efficiency groupings established in 114.2 CMR 2.16(7), Incentives.

(6) Facilities applying for increases pursuant to 114.2 CMR 2.20 must post a copy of the form entitled "Notice to Employees", which is attached to the Information Bulletin which describes the petition procedures, in at least two locations within the facility which are easily visible to all employees.

(7) Adjustments made under 114.2 CMR 2.20 may be rescinded or modified if [a] the amounts received are not used for the intended wage adjustments or [b] the quarterly reports required by 114.2 CMR 2.03(9), Quarterly Reports, are not timely filed.

(8) The 6% adjustment will be effective on October 1, 1986 for all providers who file the petition by September 15, 1986. For providers who file petitions after that date, the increase shall be effective the first day of the month following the receipt of the petition.

(9) Only one petition shall be allowed under 114.2 CMR 2.20 unless extraordinary circumstances are cited which demonstrate to the satisfaction of the Commission that another adjustment is warranted which, if approved, will result in another adjustment with a different effective date, calculated pursuant to 114.2 CMR 2.20(8).

(10) The increases granted pursuant to 114.2 CMR 2.20 shall be dependent on their being in accordance with federal law, and shall be effective only if the increases are fully reimbursable by the federal government at the medical assistance rate. If, after the granting of any increases pursuant to 114.2 CMR 2.20 the federal government determines that the increases are not in accordance with federal law and determines that the increases are not fully reimbursable by the federal government at the medical assistance rate, then the increases shall be retroactively rescinded.

(11) Facilities that have been granted petitions under 114.2 CMR 2.20 which have not been rescinded or modified under 114.2 CMR 2.20(7) may repetition to have the interim rate adjustment added to the interim rate effective October 1, 1987. To qualify for this extended adjustment, providers must provide the Commission with satisfactory evidence that the amounts previously granted have been expended for salaries in the manner intended by St. 1986, c. 279 as well as 114.2 CMR 2.00 and related Information Bulletins.

2.21: Petitions to Increase the Interim Rate Pursuant to Chapter 303 of the Acts of 1987

A provider may file one petition for an increase in the interim rate beginning July 1, 1987 and ending September 30, 1988, based on 114.2 CMR 2.21 and on St. 1987, c. 303. Such adjustments will be made for facilities that qualify according to the following criteria:

2.21: continued

(1) The facility must demonstrate that, as of the date of the petition, more than 75% of its patient population is receiving benefits under M.G.L. c. 118E, the Medical Assistance Program, or M.G.L. c. 6, § 131E, Program of Medical Assistance for the Blind.

(2) The facility must submit a listing of the actual wages paid to nurses' aides, laundry, dietary and housekeeping personnel, whether full or part-time. The wages reported for such personnel shall reflect payments made as of the latest pay period ending before July 1, 1987. The facility must file a copy of the payroll summary for the most recent pay period of these employees. If the wages reflect less than full staffing, the facility shall so state and shall document what the full staffing pattern is.

(3) An adjustment of 3% of the qualifying wages as defined in 114.2 CMR 2.21(2) will be added to the interim rate beginning July 1, 1987 and ending September 30, 1988.

(4) The adjustment of 3% of the qualifying wages will be added to the interim rate of payment, expressed in terms of *per diem*, by dividing the adjustment by the greater of actual patient days, or 96% of licensed bed capacity, for the pay period. As in all other rate computations, private reservation days and publicly-assisted furlough days must be included in the computation of actual patients days.

(5) This adjustment will be made to the interim rate notwithstanding any ceilings or caps. In calculating final rates pursuant to 114.2 CMR 2.04, facilities shall not be penalized for cost in excess of ceilings which result from participation in the wage increase program.

(6) Facilities applying for increase pursuant to 114.2 CMR 2.21 must post a copy of the form entitled "Notice of Employees" in English and Spanish, which is attached to the Information Bulletin which describes the petition procedures, in at least two locations within the facility which are easily visible to all employees.

(7) Adjustments made under 114.2 CMR 2.21 may be rescinded or modified if:
(a) the amounts received are not used for the intended wage adjustments or
(b) the quarterly reports required by 114.2 CMR 2.03(9), Quarterly Reports, are not timely filed.

(8) The increases granted pursuant to 114.2 CMR 2.21 shall depend on their being in accordance with federal law, and shall be effective only if the increases are fully reimbursable by the federal government at the medical assistance rate. If, after the granting of any increases pursuant to 114.2 CMR 2.21 the federal government determines that the increases are not fully reimbursable by the federal government at the medical assistance rate, then the increases shall be retroactively rescinded.

REGULATORY AUTHORITY

114.2 CMR 2.00: M.G.L. c. 6A, §§ 31 through 34.