114.2 CMR 5.00: PROSPECTIVE RATES OF PAYMENT TO NURSING FACILITIES

Section

5.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 5.00 governs the rates of payment effective January 1, 1998 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 5.00 is adopted pursuant to M.G.L. c. 118G.

5.02: General Definitions

Meaning of Terms. As used in 114.2 CMR 5.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 5.00 are capitalized.

Actual Utilization Rate. The percentage of occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

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.

Base Year . The calendar year or portion of the calendar year used to compute the prospective rates as defined in 114.2 CMR 5.04(2).

Building. The structure that houses residents. Building Costs include the direct cost of construction of the shell and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Case-Mix Category. One of ten categories of resident acuity that represents a range of a discrete number of Management Minutes.

Case-Mix Data. The average of the Management Minutes scores submitted by a Nursing Facility to the Division of Medical Assistance during the Base Year .

Case-Mix Group-Heavy. A peer group composed of Nursing Facilities which have an average Management Minutes score for the Case-Mix Data greater than 200 minutes.

Case-Mix Group-Light. A peer group composed of Nursing Facilities which have an average Management Minutes score for the Case-Mix Data between 30 and 200 Management Minutes.

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Change of Ownership. A *bona fide* transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the facility rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (*e.g.* drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Cost Center. Classification of similar costs, as defined in 114.2 CMR 5.04(1), for the purposes of reporting and auditing costs and establishing rates.

Department. The Massachusetts Department of Public Health.

Desk Audit. A comprehensive audit performed at the Division's offices in which the auditor evaluates the accuracy of the financial and non-financial information in the Cost Reports and supporting documentation in accordance with an audit program.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to such larger items as the Building.

Exit Conference. A conference conducted at the close of an on-site Field Audit at which Division auditors present audit findings and recommendations to the Provider and the Provider may respond to the Division's findings and present additional information for review. The conference may take place at a scheduled meeting or by telephone.

Field Audit. An audit performed on-site at the Nursing Facility in which the auditor evaluates the accuracy of the information in the Cost Reports by examining the books and records of the Facility and evaluating internal controls, observing the physical plant, and interviewing the Nursing Facility staff.

Final Plan. A plan for a substantial capital improvement involving physical changes or alterations to the Nursing Facility that changes the size and/or functions of a room or otherwise requires prior approval and plan review by the Department pursuant to 105 CMR 150.017(A): *New Construction, Alterations and Conversions*.

Generally Available Employee Benefits. Employee benefits which are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Unit located in the hospital building licensed for both hospital and Long-Term care services. It does not include free-standing Nursing Facilities owned by hospitals.

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Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the facility is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the facility's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, *et seq*.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Long Term Interest Expense. Reasonable and necessary expense incurred for the use of reimbursable loans related to the care of publicly-assisted residents. It includes all the costs of borrowing money, including, but not limited to, interest, mortgage acquisition costs, and mortgage insurance premiums.

Major Addition. A newly constructed addition to a facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A unit of measurement of resident care intensity by discrete care-giving activities, or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed bed days for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A facility's weighted average Licensed Bed Capacity for the calendar year, determined by:

(a) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level; and
(b) adding the Maximum Available Bed Days for each level; and
(c) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, points, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other long-term debt instrument.

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Non-Profit Provider. A Provider either organized for charitable purposes or recognized as a non-profit entity by the Internal Revenue Service. It includes Massachusetts corporations organized under M.G.L. c. 180; tax exempt clubs, associations, organizations, or entities; corporations organized under M.G.L. c. 156B and granted a 501(c)(3) tax exemption; and facilities owned or operated by governmental Units.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, § 71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Nursing Home Reimbursement Area, (NHRA). Three distinct geographic areas based upon the following federally designated Health Service Areas (HSAs): NHRA 1 = HSA 1; NHRA 2 = HSA 2 and 5; NHRA 3 = HSA 3, 4, and 6 and used to compute reasonable nursing costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a facility reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Personnel. The following personnel are defined in accordance with the Department's regulations at 105 CMR 150.000 (Licensing of Long-Term Care Facilities): Registered Nurse; Licensed Practical Nurse; Nurses' Aide, Nurse's Assistant, Orderlies; Dietitian; Physical Therapist; Occupational Therapist; Speech Pathologist, Audiologist; B.A. Social Worker, M.S.W. Social Worker; Social Worker complying with equivalency standards established by the Department; Food Service Supervisor; Health Service Supervisor; Director of Nurses; Supervisor of Nurses; and Medical Director.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Proprietary Provider. A Provider that does not meet the criteria specified in the definition of "Non-Profit Provider."

Proposed Rates. Rates calculated by the Division which are sent to the Provider for review before certification pursuant to 114.2 CMR 5.13(1).

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption a purchase price which exceeds the market price for a supply or services is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the prospective *per diem* rates are in effect.

Reasonable Operating Costs. Reasonable and necessary provider costs incurred to provide care to Publicly-Aided Residents and within the requirements and limitations of 114.2 CMR 5.00. The Division will determine the reasonableness and necessity of any cost by comparison to the cost of providing comparable services and by reference to the Prudent Buyer Concept.

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Related Party. An individual or organization associated or affiliated with, or which 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), 267(c) and 318 of the Internal Revenue Code of 1954 as amended provided, however, that 10% will be the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

Substantial Capital Expenditure. A capital expenditure which meets the criteria set forth in 114.2 CMR 5.12 for an administrative adjustment to the Rates.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

Urban Underbedded Area. An area defined by the Department of Public Health in its Guidelines entitled "Guidelines for Determination of Need exemptions for Long Term Care Beds Constructed in Urban Underbedded Areas."

5.03: Reporting Requirements

(1) Required Costs Reports.

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report contains the facility's claim for reimbursement and the complete financial condition of the facility, including all applicable management company, central office, and real estate expenses.

(b) Realty Company Cost Report.. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it claims management or central office expense. If these costs are claimed for reimbursement, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(2) General Cost Reporting Requirements.

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's claim for reimbursement. Providers must be able to document expenses relating to affiliated entities for which reimbursement is claimed whether or not they are Related Parties.

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(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which reimbursement is claimed, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions for which reimbursement is claimed. The Division will not reimburse the salary and fringe benefits of any individual for which the Provider does not maintain a job description and time records.

(e) Other Cost Reporting Requirements.

1. Administrative Personnel and Consultants. Providers must charge the cost of administrative personnel as defined in 114.2 CMR 5.08(1) to the appropriate Administrative and General account.

a. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

b. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Expenses which Generate Income. Providers must identify the expense accounts which generate income. The Division will offset reported ancillary income if the Provider does not identify the associated expense account.

3. Laundry Expense. Providers must separately identify the expense associated with laundry services not provided to all Residents. Providers may not claim reimbursement for such expense.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not claim reimbursement for the assets.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the facility to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers must not report such expenditures as prepaid expenses.

5. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

6. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services. The Division will limit reimbursement for such goods and services to the Related Party's cost. The Division will not reimburse Related Party salaries or other expenses unless such expenses are disclosed as Related Party payments.

7. Draw Accounts. Providers may not report or claim Proprietorship or Partnership Drawings as salary expense.

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(3) Special Cost Reporting Requirements.

(a) Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not claim reimbursement for the expenses of such programs.

1. If the Provider converts a portion of the facility to another program, the Provider must identify the existing Equipment no longer used in Nursing Facility operations and remove such Equipment from the Nursing Facility records.

2. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.

3. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

(b) Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

1. identify and claim reimbursement only for the existing Building and Improvement costs associated with the Nursing Facility. The Provider must allocate such costs on a square footage basis.

2. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the facility must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 5.02. The Provider may elect to be reimbursed for major moveable and fixed Equipment by one of two methods:

a. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Facility. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first budgeted Nursing Facility Cost Report.

b. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment, the Division will not allow major moveable Equipment as part of the facility's allowable basis. The Division will allocate and allow fixed Equipment on a square footage basis.

3. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Facility within the hospital as Additions. The Division will allocate capital expenditures related to the total plant on a square footage basis.

4. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Facility. The Provider must allocate all costs shared by the hospital and the Nursing Facility using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Facility Cost Report.

(4) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.

2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.

3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.

4. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, § 72N, the Provider must file Cost Reports for the pre-receivership reporting

period or portion thereof, within 60 days of the receiver's appointment.

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(b) Extension of Filing Date. The Director of the Bureau of Long-Term Care may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Amended Reports. The Division will not accept amended Cost Reports unless the Provider requests, in writing, that the Division correct a mechanical reporting error within ten calendar days of the date of the notice of Proposed Rates based upon the Cost Reports. At the same time, the Provider must also submit amended Report(s) clearly marked "CORRECTED" and signed by the Provider, a complete list of the changes requested, and sufficient documentation to support the requested corrections. The Director of the Bureau of Long Term Care will determine if an adjustment to correct such mechanical error and Proposed Rates is warranted.

(7) Additional Information. The Division may require the Provider to submit additional data and documentation during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports. In addition, the Division may request additional information and data relating to the operations of the Provider and any Related Party.

(8) Failure to File Timely.

(a) If a Provider does not file the required Cost Reports by the due date, the Division will delay certification of the rates for the next calendar year by 30 days for each 30 day period or any portion thereof that the reports are late. The Division will delay certification of rates only if the new rates are greater than the rates for the current year.

(b) If the Provider does not file the required Cost Reports or any other required information within six months of the due date, the Division will notify the Provider that it has not received the reports. If the Provider fails to file the required reports, the Division will terminate the Provider's rates effective the following January 1. The Division will rescind the termination when the Provider files the required reports.

5.04: Principles for Determining Prospective Rates of Payment

(1) General.

(a) Except for new facilities and facilities with Major Additions, as specified in 114.2 CMR 5.11, the Division will calculate prospective *per diem* rates for each Provider based upon the Provider's Base Year costs. In the case of Nursing Facilities which include Resident Care Units, the Division will establish a separate *per diem* rate for those beds licensed for Residential Care.

(b) Cost Centers. The Division will calculate the Provider's rates by summing the allowable *per diem* amount for each separate Cost Center. The methodology for computing the allowable *per diem* amounts for each Cost Center are set forth in the following sections of 114.2 CMR 5.00:

Nursing Costs	114. 2 CMR 5.05
Director of Nurses	114.2 CMR 5.06
Variable Costs	114.2 CMR 5.07
Motor Vehicle Costs	114. 2 CMR 5.07(3)
Administrative and General	114.2 CMR 5.08
Capital and Other Fixed Costs	114.2 CMR 5.09
Equity	114.2 CMR 5.10(a)
Use and Occupancy	114.2 CMR 5.10(b)

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(2) Base Year. Except as provided below, the Base Year for 1998 rates is 1993.

(a) New Facilities and Major Additions. The Division will calculate rates for facilities with no Base Year cost history, including New Facilities, Facilities with Major Additions, and facilities which convert to nursing home use pursuant to 114.2 CMR 5.11.

(b) Facilities sold during the Base Year. If a facility was sold during the Base Year , the Division will use the buyer's Cost Reports for the buyer's period of ownership to determine allowable Base Year Costs unless the buyer's period of ownership was of such short duration that it may not appropriately be used to project costs.

(c) Facilities closed after the Base Year. If a facility closed after the Base Year and subsequently reopened, the Division will use the Base Year Cost Report(s) to calculate the rates. If no Base Year Cost Report(s) were filed, the Division will use the latest Cost Report(s) for the facility filed prior to the Base Year. The Division will increase Reasonable Nursing and Variable Costs by an appropriate Cost Adjustment Factor.

(d) Facilities acquired by a Hospital. If a hospital acquires licensed Nursing Facility beds from a Nursing Facility, the hospital will be paid at the transferor's current rates. The transferor's Base Year costs will continue to be the basis for future rates until a year in which the hospital operated the beds becomes the Base Year under the regulation. If for any reason, the Base Year Cost Reports of the transferor have not been filed, the Division will use the latest Cost Reports of the transferor to calculate the rates. If licensed Nursing Facility beds are transferred to a hospital from more than one Nursing Facility, the Division will calculate a single set of rates for the transferee hospital by weighting the current rates of the transferors.

(e) Private Nursing Facilities. If a Nursing Facility which was a Private Nursing Facility in the Base Year and which timely filed a Base Year Cost Report, signs a provider agreement to provide services to publicly-assisted Residents in the Rate Year, the Division will use that Base Year Cost Report to calculate rates pursuant to the methodology set forth in 114.2 CMR 5.04 through 5.10. If such a facility did not timely file a Base Year Cost Report, the Division will use a Projected Cost Report and will calculate the facility's rates pursuant to 114.2 CMR 5.11.

(f) Facilities Purchased from a Receiver. Upon the sale of a facility in receivership, the Division may use a different Base Year Cost Report if the new owner demonstrates that a different Base Year more accurately reflects the reasonable and necessary costs of providing adequate resident care.

(3) Cost Adjustment Factor. The Division will increase Allowable Base Year Costs exclusive of all Fixed Costs by a Cost Adjustment Factor for 1993 to 1995 of 5.52% If there was a Change of Ownership in the Base Year , and the rates are based on the new owner's reported Base Year costs, the Division will modify the Cost Adjustment Factor to reflect the number of months from the midpoint of the new owner's reporting period to the midpoint of the prospective rate period.

(4) Rate Limitations.

(a) Medicare Upper Limit of Payment. The weighted average rates of payment may not exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement unless the Division of Medical Assistance grants an exemption from the Medicare cost limits.

(b) Private Rate Limitation. The weighted average rates of payment may not exceed the rate charged by the Provider to private residents for the same or similar services and accommodations. The Division will calculate the private rate limitation as follows:

1. The Division will determine the weighted average publicly-aided prospective rates for the Base Year and compare it to the average private rate for the Base Year.

2. If the facility's weighted average rate is greater than the average private rate, the Division will reduce the prospective rates by an amount equal to the difference between the calculated rates and the private rate, multiplied by the number of private Patient Days.

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(5) Audits. The Division will establish rates after a comprehensive Desk Audit of the Base Year Cost Report. The Division and Division of Medical Assistance will also, whenever possible, conduct on-site Field Audits to ensure the accuracy of the claims for reimbursement and consistency in reporting. Any cost for which the Provider does not produce documentation requested during a Desk or Field Audit will be disallowed.

(6) General Cost Principles. In order to be reimbursed, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost must adhere to the Prudent Buyer Concept;

(c) The cost must be for goods or services actually provided in the nursing facility; and

(d) The cost effect of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction prevails over form.

(e) The cost must actually be paid by the Provider. Examples of costs which are not considered paid for purposes of reimbursement include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;

(7) Non-Allowable Costs. The Division will not include in the rates those costs, as defined below, which are not reimbursable, are reimbursed through an allowance, or are for services which are billed directly.

(a) Non-reimbursable Costs.

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
2. Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, 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;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Any amounts in excess of any schedule of limitation contained in 114.2 CMR 5.00;
6. 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;
7. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
8. The amount by which the total compensation package, including payroll taxes and benefits, for any individual, except those individuals covered by the Administrative and General Allowance and the Director of Nurses, exceeds $75,000 per annum.
9. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;
10. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility;
11. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.

(b) Costs reimbursed through an allowance or other specified methodology.

1. Administrative and General Costs as set forth in 114.2 CMR 5.08;
2. Capital and Other Fixed Costs, as set forth in 114.2 CMR 5.09;
3. Motor Vehicle expenses as set forth in 114.2 CMR 5.07(3);
4. Working Capital interest as set forth in 114.2 CMR 5.09(3)(c).

(c) Costs for services which are billed directly. The following supplies or services must be billed directly to the purchaser in accordance with the purchaser's regulations or policies.

1. Direct physician services to the individual residents, including emergency physician services required by the Department pursuant to 105 CMR 150.000.
2. Medical Supplies.

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3. Pharmacy costs related to legend drug prescriptions and prescribed legend drugs for individual residents.

4. Direct Restorative Therapy services, except for Pediatric facilities.

5. The Division may include ancillary services and supplies in the rates in accordance with the regulations or written policy of the purchasing agency.

(8) Special Provisions.

(a) Accrued Expenses. The Division will not allow accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals permissible under 114.2 CMR 5.04(8)(b)2. If the Provider submits satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable rates.

(b) Employee Benefits. Employee Benefits include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. The Division will allow only the Provider's contribution of Generally Available Employee Benefits. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer.

1. Benefits related to salaries. The Division will limit benefits related to salaries to allowable salaries.

2. Accrued employee benefits. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken when a legal liability to pay such expenses is established. The Provider may accrue such expenses only if:

a. the benefits are stated in the Provider's written employment policy;

b. it is the Provider's actual practice to pay such benefits; and

c. the benefits are guaranteed to the employee even upon death or termination of employment.

3. Job-related Education and Staff Training Expense. The Division will allow the net cost of the Provider's contribution to the cost of required educational activities, job-related education, and staff training of employees if the educational and training activities are conducted within the New England region or New York State, are conducted by a recognized school or other authorized organization, and are directly related to improving care to Publicly-Aided Residents. In order to be reimbursed, the facility must maintain records of the expenses including 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 the subjects covered.

a. All programs designed to satisfy the nurses' aide training requirement must be certified by the Department.

b. The net cost is the cost of required educational activities less any reimbursement from grants, tuition, specific donations, employee contributions, or other sources.

c. Education expenses for Administrator-in-Training are not reimbursable.

d. Education expenses for Continuing Education Credits for licensed administrators are covered by the Administrative and General Allowance.

4. Bonuses. The Division will not reimburse bonuses related to profit, private occupancy, or to rates of reimbursement.

5. Pension Plans. The Division will reimburse reasonable and necessary expenses relating to a pension plan, subject to the reasonable cost limits set forth in 114.2 CMR 5.00, only if the pension plan provides 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.

a. Pension Plans Required by State Statute. The Division will reimburse Providers required by statute to make payments to municipal or county pension funds for the pension benefit paid by the plan to the retirees of the Nursing Facility covered by the plan. In order to be reimbursed, the Provider must provide documentation of the allocations provided to the Public Employees Retirement Administration. If the plan is a funded plan, the Provider must also submit a schedule of the individuals associated with the Nursing Facility.

5.04: continued

b. Pension Plans Not Required by State Statute. The Division will reimburse reasonable and necessary expenses relating to a pension plan if:

i. the claimed expenses represent an amount based upon fair, reasonable, and necessary compensation for services performed by employees;

ii. the claimed expenses are costs incurred on the current year payrolls and do not include payments for prior year payrolls;

iii. the pension plan does not provide for contributions by the employer based on a contingency of profit or at the discretion of the employer;

iv. any forfeiture by an employee must be applied against the cost of the pension plan to reduce the premiums paid by the employer;

v. the pension plan must have met the current requirements of and, if applicable, must have received the approval of the Internal Revenue Service. The Provider must file a copy of the pension plan and all applicable Internal Revenue Service forms documenting IRS approval.

3. Equipment Rental. The Division will allow expense to rent or lease office equipment located at the facility if the expense is reasonable and necessary and contributes to Provider efficiency.

4. Expenses which generate income. The Division will offset expenses by applicable income which includes, but is not limited to, rental of quarters to employees or others; income from meals sold to non-residents; vending machine income; and medical records income. The Division will offset vending machine income against Variable Costs. Other income will be offset against an account in the appropriate Cost Center. If the Provider has not separately identified the cost of providing laundry services to private residents as required by 114.2 CMR 5.03(2)(f)3., the Division will offset laundry income against laundry expense.

5. Payments to Related Parties. The Division will not allow payments to a Related Party unless the Provider identifies both the expenses paid to the Related Party and the cost incurred by the Related Party to provide the goods or services to the Provider. The Division will limit reimbursement of expenses paid to a Related Party to the lower of a Related Party's cost of providing the goods or services or the market price of comparable goods or services. The Division may require the Provider or Related Party to submit documentation relating to Related Party expenses and costs.

6. Services of Non-Paid Workers. The net value of services of 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 must be allowable for reimbursement purposes under 114.2 CMR 5.00. The value of the services normally provided on a voluntary basis, such as distribution of magazines and newspapers to residents, must not constitute an allowable cost. To qualify as an allowable cost, services of non-paid workers must meet the following requirements:

a. The amount allowed may not exceed that which would be paid others for similar work;

b. The amount paid by the Provider to the organization must be identifiable in the records of the Provider as a legal obligation;

c. The services must 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.

d. The services must be performed on a regular, scheduled basis and must be necessary for the provision of adequate resident care to Publicly-Aided Residents and for the efficient operation of the Provider.

e. The services must be fully disclosed on the Footnotes and Explanations page of the Cost Report. Both the total expense and the account(s) in which the expense is reported must be identified.

Example: Assume that the prevailing salary of a registered nurse is $22,000 per year for full-time services. A non-paid 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 of the services.

5.04: continued

7. Therapy Services - Indirect. Indirect Restorative Therapy services are reimbursable provided that such service is documented in a written summary, available for inspection in the facility. This summary should be in the form of a consultant log book for each discipline and should be updated at least monthly.

(e) Rates for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Department of Elder Affairs to establish and maintain a program; or

2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

(9) Retroactive Adjustments. The Division may retroactively adjust rates in certain situations which include, but are not limited to, the following.

(a) Accrued but Unpaid Expenses. If the Division learns that a Provider has failed to pay expenses which were accrued at the end of the Base Year and which were reimbursed in the rates, the Division may adjust the rates downward to remove such expenses. This does not apply to permissible vacation and sick time accruals, as defined in 114.2 CMR 5.04(8)(b)2.

(b) Errors in the Cost Reports. The Division may adjust rates if it learns that the Provider has made an error in the cost report which results in a material over-reimbursement to the Provider.

(c) Mechanical Errors. The Division may adjust rates if it learns that there is a material error in the rate calculations.

(d) Field Audit. The Division will adjust rates to reflect the results of field audits conducted by the Division or the Division of Medical Assistance.

(e) Termination of Receivership. The Division will adjust rates to reflect allowable receivership expenses as defined in 114.2 CMR 5.12(6)(d).

(f) New Facilities and Major Addition Look-Back Provisions. The Division will adjust rates to reflect the Look-Back Provisions as defined in 114.2 CMR 5.11.

(g) Administrative Adjustments. The Division will adjust rates to reflect allowable administrative adjustments as defined in 114.2 CMR 5.12.

5.05: Nursing Costs

The Division will calculate ten case mix adjusted nursing *per diem* rates based upon a facility's reasonable Base Year nursing costs and Base Year case mix data.

(1) Determination of Reasonable Nursing Costs.

(a) Nursing Costs. The costs must be associated with direct resident care personnel, be required to meet federal and state laws, and meet the general cost conditions set forth in 114.2 CMR 5.04. Nursing costs include, but are not limited to, the claimed Base Year costs for Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Nursing Workers Compensation, Nursing Payroll Tax , and Nursing Fringe Benefits, including Nursing Pension Expense.

(b) Nursing Ceiling.

1. The Division will calculate a Nursing Ceiling based upon claimed Base Year average nursing cost per management minute as follows:

a. The Division will calculate a nursing *per diem* for each facility by dividing the facility's claimed Base Year nursing costs by the greater of Base Year patient days or 96% of the Mean Licensed Bed Capacity in the Base Year times the days in the Base Year.

b. The Division will calculate the Base Year average nursing cost per Management Minute for each facility by dividing the Base Year nursing cost *per diem* by the facility's Base Year average Management Minutes score from the Case Mix Data.

c. The Division will group Providers into three NHRAs as defined in 114.2 CMR 5.02.

5.04: continued

d. The Division will calculate a Nursing Ceiling for each NHRA. The ceiling is 110% of the median claimed Base Year nursing cost per Management Minute incurred by facilities in each NHRA.

2. The Division will not allow Base Year nursing costs which exceed the facility's NHRA nursing ceiling, except that the Division will not apply the nursing ceiling to Pediatric Nursing Facilities.

(2) Calculation of Ten Nursing Per diem Rates.

(a) The Division will compare the facility's average Base Year nursing cost per management minute to the appropriate nursing ceiling. The facility's allowable Base Year nursing cost per management minute is the lower of the facility's average nursing cost per management minute or the nursing ceiling.

(b) The Division will determine the case mix adjusted Base Year nursing *per diem* rates by multiplying the facility-specific mean minutes per case mix category from the Case Mix Data by the facility's allowable nursing cost per Management Minute. If the facility-specific mean minutes per case mix category equals zero, the Division will use the industry median minutes for that category, as derived from the Case Mix Data.

(c) The Nursing Rates are the case mix adjusted Base Year nursing home rates increased by the Cost Adjustment Factor, and increased by an additional 5.43%.

5.06: Director of Nurses Costs

The Division will calculate a Director of Nurses *per diem* based upon the Provider's reasonable Base Year Director of Nurses costs.

(1) Director of Nurses Costs include Base Year costs for Director of Nurses salary, fringe benefits including pension, payroll taxes and workers compensation, and any other cost associated with the Director of Nurses.

(2) Reasonable Base Year Director of Nurses Costs are the lower of total Base Year Director of Nurses costs or $75,000.

(3) The Division will determine Allowable Director of Nurses Costs by increasing reasonable Base Year Director of Nurses Costs by the Cost Adjustment Factor and an additional 5.43%.

(4) The Division will divide Allowable Director of Nurses Costs by the greater of:

(a) 96% of current Licensed Bed Capacity for the Rate Year times the days in Rate Year; or

(b) the Actual Utilization Rate in the Base Year.

5.07: Variable Costs

The Division will calculate an allowable Variable Cost *per diem* based upon the Provider's reasonable Base Year Variable Costs.

(1) Variable Costs include, but are not limited to, the following:

(a) Total Plant, Operations and Maintenance;

(b) Total Dietary, including allowable Management Company Dietitian cost;

(c) Total Laundry;

(d) Total Housekeeping;

(e) Ward Clerks and Medical Records Librarian;

(f) Medical Director;

(g) Advisory Physician;

(h) Utilization Review Committee;

(i) Employee Physical Exams;

(j) Other Physician Services;

(k) House Medical Supplies Not Resold;

(l) Pharmacy Consultant;

5.07: continued

(m) Social Service Worker;
(n) Indirect Restorative and Recreation Therapy Expense;
(o) Other Required Education;
(p) Job Related Education;
(q) Quality Assurance Professionals;
(r) Management Minute Questionnaire Nurses; and
(s) Staff Development Coordinator

(2) Allocation of Parallel Accounts. Variable Costs also include an allocation of certain Base Year expenses associated with the following salary "parallel accounts": Non-Nursing Pensions; Non-Nursing Benefits - Other; Payroll Taxes - Other Employees; Worker's Compensation - Non-Nursing; Group Life/Health - Non-Nursing; and Non-Profit DES Claims. The Division will determine the allocation as follows:

(a) The Division will add the costs in the claimed Base Year parallel accounts;
(b) The Division will add the costs associated with the Non-Nursing positions;
(c) The Division will determine the "parallel account factor" which is the percentage of non-nursing parallel accounts to total parallel accounts.
(d) The Division will allocate a portion of the parallel accounts to the Administrative and General Cost Center by multiplying the parallel account factor by the sum of the claimed Base Year salary accounts for clerical staff and Administrator in Training. The Division will allocate the remaining portion to the Variable Cost Center.

(3) Motor Vehicle Allowance. The Division will not include Motor Vehicle expenses as allowable Variable Costs. Motor vehicles include, but are not limited to, automobiles, trucks, vans, buses and tractors. Motor vehicle expenses include, but are not limited to, depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax. The Division will include a motor vehicle allowance of $1,500 in lieu of all motor vehicle expenses. The Motor Vehicle *per diem* allowance is calculated by dividing $1,500 by Rate Year Licensed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year.

(4) Variable Cost Ceiling. The Division will calculate a variable cost ceiling as follows:

(a) The Division will group a representative sample of facilities into four groups:
1. Group 1 = Facilities in Case-Mix Group-Light and located in Health Service Area 4;
2. Group 2 = Facilities in Case-Mix Group-Heavy and located in Health Service Area 4;
3. Group 3 = Facilities in Case-Mix Group-Light and located in Health Service Areas 1, 2, 3, 5 and 6; and
4. Group 4 = Facilities in Case-Mix Group-Heavy and located in Health Service Areas 1, 2, 3, 5 and 6.

(b) The Division will calculate a Variable Cost Ceiling for each group. The ceiling is 108% of the median claimed Base Year costs reported by a representative sample of Providers in each group.
(c) The Division will not allow Base Year Variable Costs which exceed the facility's Group ceiling.

(4) Determination of Allowable Variable Cost.

(a) The Division will calculate reasonable Base Year Variable Costs by comparing the claimed Base Year costs, subject to the limitations set forth in 114.2 CMR 5.04, to the appropriate ceiling. The Division will allow the lower of the Provider's Base Year Variable Costs or the variable ceiling.
(b) The Division will calculate allowable Variable Costs by increasing reasonable Base Year Variable Costs by the cost adjustment factor and increasing the result by 5.43%.
(c) The Division will calculate an allowable variable cost *per diem* by dividing allowable Variable Costs by the greater of Base Year Patient Days or 96% of the Mean Licensed Bed Capacity in the Base Year times the number of days in the Base Year.

5.08: Administrative and General Allowance

The Division will include in each Provider's rates an Administrative and General Allowance to reimburse Administrative and General Costs.

(1) Administrative and General Costs. Administrative and General Costs include all expenses relating to the following:

(a) On-site Staff. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility.

(b) Administrative Oversight Function. Expenses related to tasks performed by persons at a management level above that of an on-site facility department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility. All costs for off-site Buildings and Equipment, office supplies, telephone, conventions and meetings, help wanted advertisement, license and dues, malpractice insurance, legal, accounting, financial and managerial services or advice including computer services and payroll processing are included. Expenses of a parent organization, management company or central office are also included to the extent that such expenses reflect costs for the above mentioned services and are related to the provision of care to Publicly-Aided Residents in Nursing Facilities located in the Commonwealth.

(c) Policy Planning Function. The policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing 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 resident admission policies and the planning of the expansion and financing of the facility.

(d) Administrative and General Costs include the amounts reported in the following accounts:

1. the portion of the "parallel accounts" allocated to the Administrative and General Allowance pursuant to 114.2 CMR 5.07(2);
2. Administrator Salaries;
3. Payroll Taxes - Administrator;
4. Worker's Compensation - Administrator;
5. Group Life/Health - Administrator;
6. Administrator Pensions;
7. Other Administrator Benefits;
8. Clerical, prior to adjustment of self-disallowed amounts;
9. EDP/Payroll/Bookkeeping Services;
10. Administrator-in-Training;
11. Office Supplies;
12. Phone;
13. Conventions and Meetings;
14. Help Wanted Advertisement;
15. License and Dues, Resident Care Related;
16. Education and Training - Administration;
17. Accounting - Other;
18. Insurance - Malpractice;
19. Other Operating Expenses ;
20. Realty Company Variable Costs;
21. Management Company allocated Variable Costs; and
22. Management Company allocated Fixed Costs.

(2) Base Year Administrative and General Cost. The Division will calculate the Base Year Administrative and General *per diem* cost for each Provider by dividing Total Claimed Base Year Administrative and General Costs by the greater of: Base Year Patient Days or 96% of Base Year Mean Licensed Bed Capacity multiplied by days in the Base Year. For multi-level nursing facilities with Resident Care Units, Base Year Reported Patient Days includes Resident Care days and Base Year Mean Licensed Bed Capacity includes Resident Care Beds.

5.08: continued

(3) Administrative and General Allowance. For rates effective January 1, 1998, the Division will establish an allowance for Administrative and General Costs of $9.74 *per diem*.

(4) Efficiency Incentive. If a Provider's Base Year *per diem* Administrative and General Cost is less than the allowance, the Administrative and General Allowance will be the its Base Year *per diem* Administrative and General Cost adjusted by the Cost Adjustment Factor plus 25% of the difference between the allowance and the Provider's Base Year *per diem* Administrative and General Cost. Example. A facility with a Base Year Administrative and General Cost *per diem* of $6.39, will have an Administrative and General *per diem* Allowance of $7.58; {[($6.39 times 1.0552)] plus [($9.74 - 6.39) times 0.25]}

5.09: Capital and Other Fixed Costs

To determine allowable capital and other fixed costs, the Division will classify Providers into two groups. There is a separate method of reimbursement for each group. Method One is set forth in 114.2 CMR 5.09(3). Method Two is set forth in 114.2 CMR 5.09(4).

(1) Provider Classifications.

(a) Method One. The Division will calculate allowable Capital and Other Fixed Costs pursuant to Method One if the facility:

1. was operational in 1995 and does not request an Administrative Adjustment for a Substantial Capital Expenditure or Major Addition on or after January 1, 1996; or
2. opened on or after January 1, 1996 pursuant to a Determination of Need approved by the Department by December 31, 1995; or
3. requested an Administrative Adjustment for a Substantial Capital Expenditure on or after January 1, 1996 pursuant to a Determination of Need or Final Plan approved by the Department by December 31, 1995.

(b) Method Two. The Division will reimburse capital costs pursuant to Method Two if the Provider opened after January 1, 1996 or requested an Administrative Adjustment for a Substantial Capital Expenditure pursuant to a Determination of Need or Final Plan either issued or transferred after December 31, 1995.

(c) Transfer of Department Approvals. Unless a Notice of Intent to Acquire the facility was filed with the Department by December 31, 1995, if the owner of the rights to a Determination of Need or a Final Plan approved by the Department by December 31, 1995 transfers those rights after December 31, 1995, the transferee's capital reimbursement will be determined pursuant to Method Two when the capital project subject to the approval becomes operational. 114.2 CMR 5.09(1)(c) applies only to transfers which require suitability approvals by the Department.

(2) Allowable Basis of Fixed Assets. The Allowable Basis of Fixed Assets is used to calculate allowable depreciation, interest, equity, and use and occupancy for Method One and the Capital Allowance for Method Two.

(a) Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.
2. Allowable Additions. The Division will reimburse Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, reimbursement is limited to the amount approved by the Department. The Division will not reimburse any Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

(b) Facilities operational in 1996.

1. Beginning Basis. The Allowable Basis of Fixed Assets effective January 1 is the Allowable Basis of Fixed Assets effective December 31 of the prior year.
2. Ending Basis. The Allowable Basis effective December 31 is the Beginning Basis plus Allowable Additions less fixed assets which were fully depreciated or removed from service during the year.

5.09: continued

(c) New Facilities and Major Additions. The allowable basis of fixed assets for new facilities and facilities with major additions in the Rate Year are the reasonable construction costs as determined below.

1. Capital projects subject to an approved Determination of Need process. For new facilities which become operational after January 1, 1997 or facilities which renovate and replace beds pursuant to a DON approval, the Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

2. Capital projects which are not subject to the Determination of Need process.

a. Urban Underbedded Areas. For facilities located in Urban Underbedded Areas exempted by the Department from the Determination of Need process, the Division will determine the Maximum Capital Expenditure of newly-constructed facilities pursuant to the methods and criteria utilized by the Department as set forth in 105 CMR 151.000 (General Standards of Construction of Long Term Care Facilities) effective 180 days after final construction plans were approved by the Department or the date on which the construction contract was signed, whichever is earlier. In determining the MCE, the Division will determine the reasonable costs of construction, land acquisition and development, pre-and post-filing planning and development, financing and major moveable equipment. For new construction the purpose of which is to replace beds or substantially renovate the existing facility, the Division will determine the Maximum Capital Expenditure pursuant to the Department's Determination of Need Guidelines for Nursing Facility Replacement and Renovation, dated May 25, 1993.

b. Twelve Bed Additions. If a facility makes a twelve-bed addition which is exempt from the Determination of Need process simultaneously with the construction of a project subject to Determination of Need approval, the allowable Basis is the lower of the provider's actual cost per bed or the cost per bed derived from the Department's Maximum Capital Expenditure amounts for each category of assets for the Determination of Need project.

(d) Free-standing Buildings converted to Nursing Facility Use. The Allowable Basis of Fixed Assets is the Net Book Value (the cost to the current owner less accumulated depreciation which would have been allowed had the building been used in the Medicaid Program).

1. Land: the original cost of the land to the current owner.
2. Building: the net book value (depreciated over 40 years with no equity supplement);
3. Improvements: the net book value of improvements made less than twenty years before conversion (depreciated over 40 years);
4. Equipment: the net book value of equipment purchased less than ten years before conversion (depreciated over ten years).

(e) Hospital Buildings converted to Nursing Facility Use. The Allowable Basis of Fixed Assets will be calculated using the DHCFP-403 Cost Report exclusive of any assets which are not appropriate or necessary for nursing care facilities such as, but not limited to, laboratories and x-ray Equipment.

(f) Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

1. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis..

2. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976. In addition, the seller's allowable Building Improvements will become part of the Allowable Building Basis of the new owner.

3. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates. The seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

5.09: continued

4. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

5. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

6. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

(g) Special Provisions.

1. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

2. Repossession by Transferor. The Division will recompute Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division 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.

(3) Method One. Under Method One, the Division will reimburse Allowable Base Year Fixed Costs including depreciation, interest, real estate taxes, Building insurance and Equipment rental as defined below:

(a) Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment, but reimbursement is limited to the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

(b) Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets.

1. Methodology. Allowable Depreciation is calculated using the straight line method.

2. Useful Lives. Except as provided below, Allowable Depreciation is calculated using the following useful lives:

5.09: continued

ASSET	TYPE	USEFUL LIFE	DEPRECIATION RATE
Building	Class I or II as classified by the Department of Public Safety	40	2.5%
	Class III or IV as classified by the Department of Public Safety	33	3.0%
	A Building owned and operated by a political subdivision of the Commonwealth or an authority or which was financed by municipal bonds.	20	5%
Building Improvements	Building or leasehold Improvements made subsequent to the beginning of the Rate Year must be pro-rated 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%
Equipment , Furniture and Fixtures		10	10%
Motor Vehicle Equipment		4	25%
Software		3	33.3%

3. Change of Ownership.

a. If there was a Change of Ownership prior to 1983, the allowable depreciation is calculated pursuant to the regulation in effect for the year in which the Change of Ownership occurred.

b. If there is a Change of Ownership on or after January 1, 1983, the allowable basis of Building and Building Improvements is depreciated over the remaining useful life plus the number of years that Building depreciation was not recaptured in determining the allowable basis for the new owner. The annual amount of depreciation on the assets that have been transferred may not exceed the amount allowed to the immediate prior owner.

(c) Working Capital Interest. Interest on short term working capital is not allowable in the calculation of the prospective rates. In lieu of these costs, the Division will include a working capital allowance for the financing of current operations. The allowance is determined by multiplying the facility's weighted average case-mix adjusted rate (less fixed costs, miscellaneous adjustments for inflation, return on equity, and the use and occupancy allowance) by 7.75%.

(d) Long Term Interest Expense.

1. Reimbursable Debt.

a. Subject to the limitations on refinancing set forth in 114.2 CMR 5.09(3)(d)1.b., the Division will recognize a long term debt as reimbursable if it is obtained to finance assets used in the care of publicly-assisted patients and if it is supported by allowable depreciable fixed assets.

i. In order for the interest related to the financing of a newly acquired fixed asset to be considered for reimbursement, the acquisition and financing must occur concurrently, except that a grace period of not more than 90 days between the date of acquisition and financing is permitted if the Provider can present sufficient documentation to support its claim that all reasonable attempts were made to finance the asset at the time of the acquisition.

ii. The Division will not allow interest expense on loans to the facility from an owner, officer, or Related Party.

iii. The Division will not offset interest income against interest expense.

5.09: continued

iv. Mortgage Acquisition Costs. Mortgage Acquisition Costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as Long Term Interest Expense. For allowable Long-Term debts secured on or after January 1, 1983, Mortgage Acquisition Costs are subject to the provisions of maximum interest rates and permanent factors, if applicable.

b. Refinancing. The Division will recognize the refinancing of an existing allowable debt as an allowable debt under the following circumstances:

i. Crossover. When the accumulated principal payments on the existing, allowable debt exceeds the accumulated depreciation allowed by the Division on the allowable fixed assets which have been financed by that debt; or

ii. Demand Note. When an existing, allowable debt becomes payable upon demand; or

iii. Lowered Expense. When the Long-Term Interest Expense over the life of the refinanced debt is lower than it would have been under the remainder of the existing, allowable debt. The Provider must submit comparative schedules showing total Long-Term Interest Expense under both the existing, allowable debt and the re-financed debt.

iv. Financing of Allowable Additions. When a Provider refinances for amounts greater than the existing, allowable debt and the additional indebtedness is used for a significant addition of allowable depreciable fixed assets. If the refinancing is for amounts greater than the existing, allowable debt on the date of the refinancing and the additional indebtedness is used for purposes other than a significant addition of allowable depreciable fixed assets, the Division will not reimburse interest expense on the additional indebtedness. When a Provider refinances for amounts greater than the existing, allowable debt on the date of refinancing and the additional indebtedness is used for the addition of allowable depreciable fixed assets which are not significant, only the portion of the refinancing related to the financing of the newly acquired fixed assets will be allowable.

c. Non-recognized Debt. If the refinanced debt is not allowable, the Division will continue to include in the rates the amount of Long Term Interest Expense which would have been incurred on the prior allowable debt. The amount of reimbursement will not exceed the amount of Long-Term Interest Expenses actually incurred by the Provider.

2. Permanent Factor for Interest. The Division will reimburse interest on an allowable debt to the extent that such debt is supported by depreciable fixed assets. Land and Mortgage Acquisition Costs are not depreciable fixed assets. The Division will calculate the percentage of allowable debt to total debt by dividing the allowable basis of depreciable fixed assets by the total amount of the reimbursable debt. Upon refinancing, the Division will recalculate the Permanent Factor by dividing the prior allowable mortgage balance by the total amount of the new debt.

3. Allowable Interest Rate.

a. Allowable long-term debts secured prior to January 1, 1983. The allowable interest rate on the allowable debt is the lower of:

i. an annually determined percentage of simple interest on all outstanding long-term loans weighted by the dollar amount borrowed, or

ii. the interest rate(s) as stated in the debt instrument(s) at the time of borrowing.

iii. The Division will not reimburse an interest rate in excess of 18% for any individual loan or obligation. Except for facilities that were granted advisory rulings concerning Long Term Interest Expense prior to January 1, 1983, the aggregate or weighted rate of interest may not exceed 15%.

b. Allowable long-term debts secured on or after January 1, 1983. The allowable interest rate is the lower of:

i. the percentage of total Long-Term Interest Expense divided by the average outstanding principal during the reporting period, or

ii. the annual percentage rate on special issues of the public debt obligations issued by the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing was incurred plus 3%.

5.09: continued

iii. The Division will not reimburse an interest rate in excess of 18% on any individual loan or obligation.

iv. The allowable interest rate applies throughout the life of any debt and will continue to apply if the Provider refinances an allowable debt which is not recognized under 114.2 CMR 5.09(3)(d)1.b.

(e) Calculation of Base Year per diem for Allowable Capital and Other Fixed Costs.

1. The Division will calculate total Allowable Base Year Capital and Other Fixed Costs by adding allowable depreciation, allowable Long Term Interest Expense, Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment; the Non-Income portion of the Massachusetts Corporate Excise tax; Building Insurance; and Rental of Equipment located at the facility.

2. The Division will calculate Allowable Fixed Costs *per diem* by dividing Allowable Base Year Capital and Other Fixed Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year.

(4) Method Two. Providers reimbursed under Method Two will receive a Capital Allowance in lieu of all capital and other fixed costs.

(a) For rates effective January 1, 1998, the allowance is $5.61 *per diem*.

(b) Transition Period Capital Allowance for Rates Effective January 1, 1998.

1. The Division will calculate each Provider's Allowable Base Year *per diem* Capital and Other Fixed Costs which include allowable depreciation, Financing Contribution and other allowable Fixed Costs.

a. Depreciation. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

b. Financing Contribution. The Financing Contribution is calculated by applying an the Federal Hospital Trust Fund rate effective October, 1995, or 6.375%, to the Allowable Book Value at the end of the Base Year. The Allowable Book Value is the allowable basis less all accumulated depreciation allowed in rates of payment for Publicly-Aided Residents, except allowed Building depreciation expense which occurred between January 1, 1983 and December 31, 1992.

c. The Division will calculate reasonable Base Year Capital and Other Fixed Costs by adding allowable depreciation, the financing contribution, Real Estate Taxes; Personal Property Taxes on the Nursing Facility Equipment ;the Non-Income portion of the Massachusetts Corporate Excise tax; Building Insurance; and Rental of Equipment located at the facility.

d. The Division will calculate Allowable Base Year *per diem* Capital and Other Fixed Costs by dividing reasonable Base Year Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year. Allowable Base Year *per diem* Capital and Other Fixed Costs may not exceed $16.00 *per diem*.

2. If the Provider's Base Year *per diem* Capital and Other Fixed Costs exceeds the Capital Allowance, the Transition Period Capital Allowance will be the lower of $13.40 or the sum of the Capital Allowance plus 75% of the difference between such allowance and the facility's Base Year *per diem* Capital and Other Fixed Costs.

5.09: continued

3. If the Provider's Base Year *per diem* Capital and Other Fixed Costs is less than the Capital Allowance, the Capital Allowance will be the facility's Base Year *per diem* Capital and Other Fixed Costs plus 30% of the difference between the Capital Allowance and the facility's Base Year per diem Capital and Other Fixed Costs.

(c) Facilities that are leased or rented. The Base Year *per diem* Capital and Other Fixed Costs for the real property of a Nursing Facility that is leased or rented is limited to the lower of the following:

1. Actual rental expenses paid;
2. Average rental or ownership costs of comparable Providers; or
3. The transition period capital allowance determined pursuant to 114.2 CMR 5.09(4)(b).

5.10: Equity and Use and Occupancy Allowance

The Division will include a return on Average Equity Capital for Proprietary Providers that are reimbursed for Capital and Other Fixed Costs under Method One. The Division will include a Use and Occupancy Allowance for certain Non-Profit Providers that are reimbursed for Capital and Other Fixed Costs under Method One.

(1) Average Equity Capital. Average Equity Capital is the average of the difference between the Provider's Allowable Basis of Fixed Assets as determined under 114.2 CMR 5.09, and the Provider's allowable long-term liabilities at the beginning and end of the year. For equity, allowable long-term liabilities are total allowable debt supported by total allowable assets, including land.

(a) The Division will reduce Average Equity Capital by Building Depreciation allowed in prior years except for the allowable Building Depreciation expenses which occurred between January 1, 1983 and December 31, 1992. The Division will also reduce Average Equity Capital by depreciation allowed on Improvements, Equipment, and Software.

(b) The Division will not include Mortgage Acquisition Costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in Buildings and/or Equipment not located at the Nursing Facility, in Average Equity Capital.

(c) The Division will not reduce Average Equity Capital by long-term loans for which interest has been excluded.

(d) Equity Supplement. The Division will include an Equity Supplement in the Average Equity Capital calculation of Providers operational in the period from July 1, 1976 through December 31, 1982, and which have not had a Change of Ownership after January 1, 1983. The Equity Supplement is an amount equal to the annual Building depreciation allowed by the Division, 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.

(e) If a facility replaces beds, reimbursable equity will be recomputed using the newly established allowable fixed assets and allowable debt, exclusive of equity supplement, if any, which was previously granted for the structure to be replaced by the new construction.

(f) Calculation of Average Equity Capital Allowance. The average equity capital allowance is calculated by multiplying Average Equity Capital by 7.875%.

(g) The Division will calculate allowable Average Equity Capital *per diem* by dividing the Average Equity Capital Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate in the Base Year.

(2) Use and Occupancy Allowance for Non-profit Providers.

(a) The Division will include a Use and Occupancy Allowance in the rates of Non-Profit Providers that have maintained a public occupancy rate, including Medicaid, Massachusetts Commission of the Blind, and Medicare Patient Days, of at least 70%.

(b) The Division will calculate the Use and Occupancy Allowance by using the methodology set forth in 114.2 CMR 5.10(1) and dividing the result by three.

5.10: continued

(c) The Division will calculate an allowable Use and Occupancy *per diem* by dividing the Use and Occupancy Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate in the Base Year.

5.11: New Facilities and Major Additions

(1) Projected Rates. The Division will calculate projected rates for New Facilities, Facilities with Major Additions, and Facilities which convert to Nursing Facility Use in the Rate Year.

(a) Projected Cost Report. The Provider must submit a projected cost report which projects its costs and patient days for a 12-month period commencing with the first date of licensure.

(b) Effective Dates. Projected Rates will be effective from the first date of licensure. If the Projected Rates become effective prior to July 1, the rate will be effective through December 31 of the first Rate Year. If the Projected Rates become effective after July 1, the rates will be effective through the end of the second Rate Year.

(c) Projected Rate Methodology. The Division will calculate projected rates using the lower of the Provider's projected costs as follows:

1. Nursing and Director of Nurses Costs: the lower of projected costs or the 1994 industry-wide median cost per minute inflated by 7.75%;
2. Variable Costs: the lower of projected costs or the 1994 industry-wide median Variable Costs inflated by 7.75%;
3. Administrative and General Costs: the lower of projected costs or the 1993 Base Year Median Costs inflated by 5.52%;
4. Allowable Basis of Fixed Assets:

a. For New Facilities and Facilities with Major Additions, allowable construction costs will be limited to the Maximum Capital Expenditure amounts as approved by the Department. If the Department amends the approved Maximum Capital Expenditures for any category more than one year after the facility or any portion of the facility has become operational, the Division will not retroactively adjust rates already set to reflect the amendment.

Example: Where a New Facility or Major Addition is opened and at least one bed has been licensed as of August 15, 1994 and final costs have been submitted to the Department on September 3, 1995, the additional costs will not be applied retroactively but rather, will be recognized in the rates set for the following calendar year.

(2) Facilities which opened before December 31, 1994.

(a) Look Back Rates. The Division will calculate audited look-back rates for the period from the date of opening to the end of the first full year of operation. The first full year of operation is the first full calendar year in which the provider operated at its full licensed bed capacity.

1. Cost Base. The rates will be calculated using the cost report for the look back rate year.
2. Ceilings. The ceilings are based on industry-wide costs for the rate year calculated pursuant to the methodology in regulation effective in that year.
3. Fixed Costs. For a period not to exceed the first 12 months of operation, Allowable Capital and Other Fixed Costs will be divided by the greater of actual patient days or 96% if Maximum Available Bed Days.

(b) Off-base Rates. The Division will calculate Off-Base Rates for each year until the facility's first full year of operation becomes the industry-wide base year.

1. Cost Base. The rates will be calculated using the cost report for the first full year of operation inflated by the appropriate Cost Adjustment Factor.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings inflated by the appropriate Cost Adjustment Factor.

(3) Facilities which opened on or after January 1, 1995.

(a) Look back Rates. The Division will calculate audited look-back rates for the period in which Projected Rates were in effect, for a period not to exceed 18 months.

5.11: continued

1. Cost Base. The rates will be calculated using the cost report for the look back rate year.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings adjusted by the appropriate Cost Adjustment Factor.
3. Fixed Costs. Unless the Provider is reimbursed for Capital and Other Fixed Costs under Method Two, for a period not to exceed the first 12 months of operation, Allowable Capital and Other Fixed Costs will be divided by of licensed bed capacity or actual Patient Days for the look-back period.

(b) Off-Base Rates. If the facility opened after July 1, the Division will calculated an audited Off-Base Year rates for the second year of operation.

1. Cost Base. The rates will be calculated using the costs from the cost report for the first year of operation.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings inflated by the appropriate Cost Adjustment Factor.

(4) Private Nursing Homes. If a Private Nursing Facility that has not timely filed a timely filed a Base Year Cost Report with the Division subsequently signs a provider agreement to provide services to publicly-assisted Residents, the Division will calculate rates under the methodology set forth in 114.2 CMR 5.11(1)(b) except that Allowable Capital and Fixed Costs will be reimbursed under Method Two. The Provider must document the historical costs of fixed assets.

5.12: Petitions for Administrative Adjustments to Prospective Rates

(1) Administrative Adjustment to Prospective Rates of Payment. A Provider may petition for an administrative adjustment to its rates only for circumstances set forth in this section.

(2) Requirements for Administrative Adjustments.

(a) A petition for an administrative adjustment must include the following:

1. The Provider's name, address and the rates assigned by the Division;
2. A detailed explanation, under oath, of the basis upon which said increase is sought;
3. A demonstration that an increase in specific costs are not already compensated by other portions of the prospective rates;
4. Information sufficient for the Division to determine the appropriate Cost Center for the expenditure for which reimbursement is claimed.

(b) The petitioner must provide any other information which the Division requires. If the petitioner fails to provide information requested by the Division within 30 days of such request, the Division will deny the petition.

(c) The Division will suspend review of any petition if the Provider has failed to submit reports or other information required by 114.2 CMR 5.03 in a timely manner. If the Provider fails to file the required information within 60 days after notification by the Division, the Division will dismiss the petition for administrative adjustment.

(d) The Division will suspend review of any petition if the Department notifies the Provider that it has identified a quality of care problem.

(e) The Division will review petitions in accordance with the criteria set forth in the regulation in effect in the year in which they are received by the Division, notwithstanding the effective date which is prescribed by 114.2 CMR 5.12(5).

(3) Standard of Review. In reviewing petitions, the Division will take into consideration the following:

(a) Whether the administrative adjustment amount would result in a significant difference in the rates;

(b) The costs of other Providers offering the same or comparable level of care;

(c) Consistency of cost increases whether for wages, nursing costs per Management Minutes, or other cost levels during the period; and

(d) The collectibility of over-payments by the Division of Medical Assistance. The Division will notify the Division of Medical Assistance of the petition.

5.12: continued

(4) Effective Date. An administrative adjustment will be effective on the later of the date the petition was filed with the Division or the date on which the actual petitioned event occurred, whichever is later.

(5) Types of Petitions.

(a) Substantial Capital Expenditures. A Provider may petition for an administrative adjustment for a substantial capital expenditure if the Provider has either made, or expects to make, a substantial capital expenditure for a single project which meets the criteria set forth below. If the Provider has not yet incurred the expense, it must submit satisfactory evidence of its commitment to incur the expenditure. The Provider may petition for recognition of increased depreciation and interest expense as a result of the expenditure. The Provider may not petition for Mortgage Acquisition Costs or for an equity adjustment.

1. Expenditures not subject to Determination of Need. The amount of the expenditure must be at least five times the allowable annual Base Year depreciation expense. For Building cost, the expenditure must be at least five times the allowable Base Year depreciation on Building and existing Improvements. For Improvements, the expenditure must be at least five times the allowable Base Year depreciation on Improvements. For Equipment, the expenditure must be at least five times the allowable Base Year depreciation on Equipment.

2. Substantial Capital Expenditures Subject to Determination of Need. If the capital expenditure is subject to Determination of Need approval, the Provider may petition for an administrative adjustment after the Department has determined that need exists for the project and after the time for making an appeal to the Health Facilities Appeals Board has expired or all administrative and judicial reviews of the Department's determination have been concluded. The Provider may petition for an adjustment before the Department has made a determination on the project if the Commissioner of Public Health requests that the Division determine the appropriate amount of an adjustment before a Determination of Need is made with respect to the expenditure or change proposed by the Provider.

(b) New Governmental Requirements. A Provider may petition for an administrative adjustment if it has incurred, or presents satisfactory evidence of a commitment to incur, substantially different costs necessary to satisfy new requirements of a governmental Unit of the Commonwealth or of the federal government provided that the new requirements are related to resident care. An increase in existing governmental requirements is not considered a new government requirement. The Division will not grant a request for an administrative adjustment for costs incurred to correct Department of Public Health resident care deficiencies.

(c) Certain Increases in Operating Costs. A Provider may petition for an administrative adjustment if it has experienced unusual and unforeseen increases in operating costs which are not reflected in the rates. Unusual and unforeseen circumstances are events of catastrophic nature (*i.e.* fire, flood, or earthquake). The cost increases must gravely threaten the financial stability of the Provider. In measuring the degree to which the financial stability of the Provider is gravely threatened, the Division will consider all of the Provider's expenditures.

(d) Receiver Fees. A receiver appointed under M.G.L. c. 111, § 72N may petition for a rate adjustment to reimburse reasonable receiver compensation and payment of his or her bond.

1. The receiver must submit detailed invoices that document the hours expended, a brief description of each activity, and the hourly rate. The Division will limit reimbursement to the reasonable and necessary cost to safeguard the health, safety and continuity of care to residents and to protect them from adverse health effects of unsuitable transfer.

2. The Division will limit reasonable receiver compensation to the lower of actual receiver fees or $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. The Division may include additional receiver compensation if both the Department of Public Health and the Division of Medical Assistance approve additional compensation to the receiver due to unique circumstances. The Division, the Department, and the Division of Medical Assistance will evaluate such requests for additional compensation for reasonableness.

3. The Division will calculate a *per diem* amount to be added to the rates by dividing allowable receiver compensation by Medicaid patient days.

5.12: continued

4. Only those expenses unique to the duties of the receiver discharged pursuant to M.G.L. c. 111, § 72N will be included as reasonable compensation under this provision. All other receivership expenses are subject to the limitations set forth in 114.2 CMR 5.05 through 5.10. When the receivership is terminated, the Division may adjust the rates to remove the costs of the receivership.

(e) Nursing Ceiling Petition. Effective October 1, 1996, facilities which demonstrate that over 75% of residents have a primary diagnosis of multiple sclerosis may request exemption from application of the nursing ceiling.

(f) Facilities in Certain Service Areas. A Provider may request an administrative adjustment if: its percentage of Medicare, Medicaid and Commission for the Blind patients to total patients is 90% or more in the year two years prior to the Petition; it is located within 2.5 miles of a sole community hospital; and more than ten percent of its Nursing and Variable Costs were disallowed. If a Nursing Facility meets these criteria, the Division will adjust the rates to reimburse the lower of the facility's total disallowed Nursing and Variable Costs, or $300,000.

(g) Geographically Isolated Facilities. Facilities which meet the criteria set forth in St. 1995, c. 39, § 48 may petition for adjustment of its allowable nursing and variable costs to reflect the costs which the Division determines to reasonably result from the facility's geographic location.

(h) Transition Petition for Public Medical Institutions. To facilitate the smooth transitition of Public Medical Institutions (PMI) to the same cost limits generally applicable to all nursing facilities, a transition petition for financially threatened PMIs is provided.

A PMI may request, in writing, that the Division certify rates effective January 1, 1998 which are equal to the PMI's rates in effect on December 31, 1997. The PMI must demonstrate to the satisfaction of the Division that it meets the following criteria:

1. the impact of the 1998 reimbursement system would result in a reduction of 10% or greater in the weighed average *per diem* rate; and
2. the impact of the 1998 reimbursement would result in a significant financial hardship, such that the financial stability of the PMI would be threatened; and
3. the PMI was granted a petition for rates set effective January 1, 1997.

The PMI must demonstrate that all reasonable steps to control spending are being taken and that the PMI cannot rectify its financial situation by the immediate implementation of more efficient and economical operations.

(6) Recommendation of Director of Bureau of Long-Term Care. After review of the petition, the Director of the Bureau of Long-Term Care will report his recommendations in writing to the Commissioner of the Division and to the petitioner, stating his reasons in detail. The Provider will have ten days to file objections, arguments and comments with the Division concerning the recommendations of the Director.

(7) Retroactive Reviews. The Division may require that the Provider demonstrate that the changes in costs have actually occurred and that the year-end Cost Report Substantiates the financial condition stated in the Provider's petition. If the Provider fails to provide evidence of such changes within 45 days of the Division's request, the Division may retroactively reverse the adjustment.

5.13: Special Provisions

(1) Notice of Proposed Prospective Rates.

(a) Desk Audit. Prior to certification of rates based upon a Desk Audit, the Division will send a notice of the Proposed Rates and a copy of the adjustments to the Provider at least 10 calendar days prior to the scheduled date of certification. The Provider may comment, in writing, on the Proposed Rates and adjustments during the period between the notice and the scheduled date of Division action. If the Provider requires additional time to respond, the Provider may request that the Division postpone the scheduled certification. The Provider may also request that the Division permit it to file an amended Cost Report pursuant to 114.2 CMR 5.03(6).

5.13: continued

(b) Field Audit. In the case of rates which are amended solely to incorporate Field Audit adjustments which have been disclosed and discussed at an Exit Conference, the Division will provide a copy of the Field Audit adjustments to the Provider subsequent to the Exit Conference. The Division will not send a notice of the Proposed Rates which are based upon the Field Audit prior to their certification.

(2) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(3) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 5.00 within 30 calendar days after the Division files the rate with the Secretary of the Commonwealth. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal .

(4) Adjustments to the Prospective Rates. The Division may at any time, adjust the Provider's rates if the Provider has reduced costs by eliminating services or transferring costs or services to other persons, entities or programs.

(5) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 5.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 5.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(6) Severability. The provisions of 114.2 CMR 5.00 are severable. If any provision of 114.2 CMR 5.00 or the application of any provision of 114.2 CMR 5.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 5.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 5.00: M.G.L. c. 118G.