

957 CMR 7.00: NURSING FACILITIES COST REPORTING REQUIREMENTS

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7.01: General Provisions

957 CMR 7.00 governs the cost reporting requirements for Nursing Facilities.

7.02: Definitions

All defined terms in 957 CMR 7.00 are capitalized. As used 957 CMR 7.00, unless the context requires otherwise, terms have the following meanings:

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

Adjudicatory Proceeding. A proceeding before an agency in which the legal rights, duties or privileges of specifically named persons or entities are required by constitutional right or by any provision of the General Laws to be determined after an opportunity for an agency hearing.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; workers' compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisements; licenses and dues (resident-care related); education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs.

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 2.00: *Nursing Home Administrators*.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building Costs. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures 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.

Capital Costs. Capital Costs include building depreciation, Financing Contribution, building insurance, real estate taxes, non-income portion of Massachusetts Corporate Excise Taxes, other rent and Other Fixed Costs.

Center. The Center for Health Information and Analysis established under M.G.L. c. 12C.

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 Provider 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.

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CMS. The federal Centers for Medicare & Medicaid Services.

Department. The Massachusetts Department of Public Health.

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. Direct Restorative Therapy Services include supervisory, administrative, and consulting time associated with provision of the services. These include, but are not limited to, reviewing pre-admission referrals, informally communicating with families, scheduling treatments, completing resident care documentation including MDS documentation, screening of patients, writing orders, meeting with aides to discuss patients, consulting with physicians and nurse practitioners, managing equipment and assessing equipment needs of patients.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs.

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

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

Hospital-based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider 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 Provider's increased productivity, greater capacity, or longer life.

Indirect Restorative Therapy. Indirect Restorative Therapy Services consist only of services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide the following: orientation programs for aides and assistants; in-service training to staff; consultation and planning for continuing care after discharge; pre-admission meetings with families; quality improvement activities such as record reviews, analysis of information and writing reports; personnel activities including hiring, firing, and interviewing; rehabilitation staff scheduling; and attending team meetings including quality improvement, falls, skin team, daily admissions, interdisciplinary, departmental staff, discharge planning, and family meetings when the resident is not present.

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.

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: *Definitions*, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department of Public Health. The Department of Public Health issues a license for a particular level of care.

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Massachusetts Corporate Excise Tax. Those taxes that 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 beds 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 Provider'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;
- (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, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond, or other long-term debt instrument.

Nursing Costs. Nursing costs include the Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers' Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

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 MassHealth. It includes facilities that operate a licensed Residential Care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include 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.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical director; advisory physician; utilization review committee; employee physical exams; other physician services; house medical supplies not resold; pharmacy consultant; social service worker; Indirect Restorative Therapy and recreation therapy expense; other required education; job related education; quality assurance professionals; management minute questionnaire nurses; staff development coordinator; motor vehicle expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General 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 Provider 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 MassHealth agency. It also includes days for which a bed is held vacant and reserved for a non publicly aided resident.

Presiding Officer. The individual(s) authorized by law or designated by the Center to conduct an Adjudicatory Proceeding.

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

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

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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 subdivision of the Commonwealth. Publicly-aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is 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, mothers-in-law, brothers-in-law, and sisters-in-law.

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed.

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: *Licensing of Long-term Care Facilities* for residents who do not routinely require nursing or other medically-related services.

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

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*.

7.03: Reporting Requirements

(1) Required Cost Reports.

- (a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility cost report each calendar year with the Center. The Nursing Facility cost report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses. If a Provider has closed on or before November 30th, the Provider is not required to file an HCF-1 report.
- (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 with the Center.
- (c) Management Company Cost Report. A Provider must file a separate management company cost report with the Center for each entity for which it reports management or central office expenses related to the care of Massachusetts Publicly-aided Residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-aided Residents in Massachusetts.
- (d) Financial Statements. If a Provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than 957 CMR 7.00, the Provider must file a complete copy of its audited financial statements with the Center, that most closely correspond to the Provider's Nursing Facility cost report fiscal period. If the Provider or its parent organization does not obtain audited financial statements, the Provider must file with the Center a copy of its unaudited financial statements that most closely correspond to the Nursing Facility cost report fiscal period. Financial statements must accompany the Provider's Nursing Facility cost report filing. Nothing in this section shall be construed as an additional requirement that nursing homes complete audited, financial statements solely to comply with the Center's reporting requirements.

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(e) CMS-2540 Reports. State operated Nursing Facilities that meet the definition in 42 CFR 433.50(a)(i) must file a CMS-2540 report with the Center annually. The State operated Nursing Facility must report the final disposition made by the Medicare intermediary.

(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 reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts Publicly-aided Residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, 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 that the Provider identifies as related to the care of Massachusetts Publicly-aided Residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Indirect Restorative Therapy Services Record. Providers must maintain a record of Indirect Restorative Therapy services documented by a written summary available for inspection in the Nursing Facility as required by the Department in accordance with 105 CMR 150.010(F): *Records and Reports*.

(f) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:
 - a. 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. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and
 - c. Expenses related to 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 Provider, 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 Provider.
 - d. Providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.
 - e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.
2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.
3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.

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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 that are no longer used to provide care to Publicly-aided Residents and may not identify associated expenses as related to the care of Massachusetts Publicly-aided Residents.
 - 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 Provider to the cost report when Equipment is retired.
 - e. Major Repair Projects. 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 may not report such expenditures as prepaid expenses.
5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.
6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as other assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.
7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.
8. 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.
- (g) Special Cost Reporting Requirements.
 1. 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 identify expenses of such programs as related to the care of Massachusetts Publicly-aided Residents.
 - a. If the Provider converts a portion of the Provider 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.
 - b. 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.
 - c. 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.
 2. 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 DHCNP-403 Hospital Cost Report and any successor state agency template cost report. The Provider must:
 - a. identify the existing Building Costs and Improvement costs associated with the Nursing Facility. The Provider must allocate such costs on a square footage basis.

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b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 957 CMR 7.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

i. 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 that clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Center with its first notification of change in beds.

ii. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment, the fixed Equipment will be allocated to the extent allowable on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Facility within the hospital as Additions. Capital expenditures that relate to the total plant will be allocated to the extent allowable on a square footage basis.

d. 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 used in preparing the Nursing Facility cost report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, 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) Payments to related parties. Expenses otherwise allowable shall not be included for purposes of determining rates under 101 CMR 206.00: *Standard Payments to Nursing Facilities* where such expenses are paid to a Related Party unless the Provider identifies any such Related party and expenses attributable to it in the reports submitted under 957 CMR 7.00 and demonstrates that such expenses do not exceed the lower of the cost to the Related Party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Center may request either the Provider or the Related Party, or both, to submit information, books and records relating to such expenses for the purpose of determining whether the expenses are allowable;

(d) Employee Benefits. Only the Provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer. To qualify as a Generally Available Employee Benefit, the Provider must establish and maintain evidence of its nondiscriminatory nature. Generally Available Employee Benefits shall include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement shall not be included for calculation of prospective rates. Benefits which are related to salaries shall be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel will be part of the other operating cost center. Benefits that are related to the Director of Nurses, including pensions and education, shall be part of the Nursing Cost Center. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the Provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established;

(e) The cost must be for goods or services actually provided in the Nursing Facility;

(f) The cost must be reasonable; and

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(g) The cost must actually be paid by the Provider. Costs not considered related to the care of Massachusetts Publicly-aided Residents include, but are not limited to: costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates.

(h) A Provider must report the following costs as non-allowable 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 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. 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;
6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies not registered with the Department under regulation 105 CMR 157.00: *The Registration and Operation of Temporary Nursing Service Agencies* or paid for at rates greater than the rates established by EOHHS pursuant to 101 CMR 345.00: *Temporary Nursing Services*;
8. Any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the Nursing Facility;
9. All legal expenses, including those accounting expenses and filing fees associated with any appeal process;
10. Prescribed legend drugs for individual patients;
11. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income and medical records income. Vending machine income shall be recovered against Other Operating Costs. Other recoverable income shall be recovered against an account in the appropriate cost group category, such as Administrative and General Costs, Other Operating Costs, nursing costs, and capital costs. The cost associated with laundry income which is generated from special services rendered to private patients shall be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (*e.g.*, dry cleaning, *etc.*). In the event that the cost of special services cannot be determined, laundry income shall be recovered against laundry expense;
12. Costs of ancillary services required by a purchasing agency to be billed on a direct basis, such as prescribed drugs and direct therapy costs; and
13. Accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, shall not be included in the prospective rates. Upon receipt of satisfactory evidence of payment, the adjustment will be reversed and include that cost, if otherwise allowable, in the applicable prospective rates.

7.04: Filing Deadlines

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

(a) 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.

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- (b) 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 current reporting period or portion thereof, within 60 of the receiver's appointment.
- (2) Extension of Filing Date. The Center may grant a request for an extension of the filing due date for a maximum of 30 calendar days. In order to receive an extension, the Provider must:
 - (a) submit the request itself, and not by agent or other representative;
 - (b) demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
 - (c) file the request with the Center no later than 30 calendar days before the due date.
- (3) Administrative Bulletin. The Center may modify the filing deadlines by issuing an Administrative Bulletin 30 days prior to any proposed change.

7.05: Incomplete Submissions

If the Cost Reports are incomplete, the Center will notify the Provider in writing within 120 days of receipt. The Center will specify the additional information that 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 1st of the year the Cost Reports are filed, whichever is later. If the Center 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.

7.06: Audits

The Center and EOHHS may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Center has accepted the Provider's Cost Reports.

7.07: Penalties

- (1) The Center may impose a fine of up to \$500 on Providers that knowingly fail to file or that knowingly file falsified data.
- (2) If a Provider has without justifiable cause refused to furnish the Center with information as required by 957 CMR 7.00, the Center may petition the Superior Court to issue an order directing all Governmental Units to withhold payment to the Provider until further order of the Court.
- (3) The Center may refer delinquent Providers to EOHHS, with recommendations that EOHHS impose penalties, including:
 - (a) Reduction in delinquent Providers' rates;
 - (b) Removal of delinquent Providers from the list of eligible Providers; and
 - (c) Any other penalty authorized by M.G.L. c. 118E or applicable regulations.
- (4) The Center may refer delinquent Providers or Providers that knowingly file falsified information to the appropriate licensing authority, which may seek suspension or revocation of the Providers' license.
- (5) Before assessing a penalty, the Center shall notify the Provider that has failed to comply with the requirements of 957 CMR 7.00 that it has the right to request a hearing in accordance with M.G.L. c. 30A, § 10.
- (6) If a hearing is timely requested in writing, the Center, including through a Presiding Officer, will conduct the hearing in accordance with 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure*. After the hearing, the Center shall render a written decision and may assess a civil penalty pursuant to 957 CMR 7.07(1).

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(7) After the issuance of a final decision, except where any provision of law precludes judicial review, a Provider aggrieved by such final decision may seek judicial review thereof in accordance with M.G.L. c. 30A, § 14.

7.08: Administrative Bulletins

The Center may issue Administrative Bulletins to clarify its policies on and understanding of substantive provisions of 957 CMR 7.00 and to specify information and documentation necessary to implement the data collection requirements of 957 CMR 7.00. Such bulletins shall be deemed to be incorporated in the provisions of 957 CMR 7.00.

7.09: Severability

The provisions of 957 CMR 7.00 are severable. If any provision of 957 CMR 7.00 or the application of any provision of 957 CMR 7.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 957 CMR 7.00 or the application of any other provision.

REGULATORY AUTHORITY

957 CMR 7.00: M.G.L. c. 12C.