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DATE: November 20, 2018
TO: Interested Parties
FROM: Stefanie Nadeau, Director, Office of MaineCare Services
SUBJECT: **Emergency Rule Adoption:** 10-144 C.M.R. Ch. 115, Principles of Reimbursement for Residential Care Facilities – Room and Board Cost

This letter gives notice of emergency rule: 10-144, C.M.R. Ch. 115, Principles of Reimbursement for Residential Care Facilities -Room and Board Cost

The Department of Health and Human Services (“the Department”) adopts these emergency rule changes in 10-144 C.M.R Chapter 115, Principles of Reimbursement for Residential Care Facilities – Room and Board Costs to comply with (1) Public Law 2017, ch. 304 (“The First Act”) and (2) Public Law 2017, ch. 460, *An Act To Amend Principles of Reimbursement for Residential Care Facilities and An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government* (“The Second Act”).

First Act requires the following changes:

- A residential care facility that experiences an unforeseen and uncontrollable event during a year which results in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance.
- Section 20.5 - New Construction, Acquisitions, and Renovations involving capital expenditures is updated to \$500,000 from \$350,000.
- Costs incurred by residential care facilities to comply with changes in federal or state laws, regulations, and rules or local ordinances and not otherwise specified in rules adopted by the Department are considered reasonable and necessary. Reimbursement for additional regulatory costs shall be paid via a supplemental payment that is added to the per diem rate until the Department adjusts the routine limit, as applicable, to fairly and properly reimburse facilities for these costs.

These changes shall have a retroactive effective date of November 1, 2017.

The Second Act requires the following changes:

- For the state fiscal year ending June 30, 2020 and each year thereafter, the MaineCare payment rates attributable to wages and salaries in routine services costs for Section 97, Private Non-Medical Institution Appendix C providers must be increased by an inflation factor in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index – medical care services index from the prior December for professional services, nursing home, and adult day care services.

- Effective August 1, 2018, for the state fiscal year ending June 30, 2019, a special supplemental allowance must be made to Appendix C PNMI's to provide for increases in wages and wage-related benefits in the routine cost component. An amount equal to ten percent (10%) of wages and associated benefits and taxes in the routine cost component as reported on each facility's as-filed cost report for its fiscal year ending in calendar year 2016 must be added to the cost per resident day in calculating each facility's prospective rate, notwithstanding any otherwise applicable caps or limits on reimbursement. This supplemental allowance must also be allowed and paid at final audit to the full extent that it does not cause reimbursement to exceed the facility's allowable cost per day in the routine cost component in that fiscal year.

These changes shall have a retroactive effective date of August 1, 2018.

The First and Second Acts require Extraordinary Circumstance Allowance (ECA), regulatory compliance costs, inflation factor, and special wage allowance changes for Residential Care Facilities and MaineCare Section 97, Private Non-Medical Institution (PNMI) Services-Appendix C providers. The Department finds that these changes must be implemented immediately through emergency rulemaking. Separately, the Department is implementing changes required in the First and Second Acts in 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, and those changes are major substantive. Pursuant to 5 M.R.S. § 8072 "regular" major substantive rule changes are not legally effective until they are approved by the Legislature and finally adopted by an agency, which can take over a year. As such, because the Department seeks to implement the Section 97 changes simultaneously with these state rule changes (in order to treat providers equitably), it must do so through emergency rulemaking. These changes will improve the financial condition of Residential Care Facility providers, and protect against a threat to public health and safety posed by instances of providers closing. The changes are a benefit to providers and otherwise have no adverse impact on either MaineCare providers or members.

The emergency adoption under 5 M.R.S. § 8054 will enable the rule changes to take effect immediately, and pursuant to 22 M.R.S. § 42(8), retroactively.

Rules and related rulemaking documents may be reviewed at and printed from MaineCare Services website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or, for a fee, interested parties may request a paper copy of rules by calling 207-624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

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DEFINITIONS

- 1 **Accrual Method of Accounting** is when revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.
- 2 **Allowable Costs** are those operating costs remaining after the adjustments required by the Principles of Reimbursement have been applied to the provider's total operating costs reported in the annual cost reports.
- 3 **Allowances** are deductions granted for damages, delay, shortage, imperfections, or other causes, excluding discounts and returns.
- 4 **Alzheimer's/Dementia Care Unit** is a unit that provides care/services in a designated, separated area for residents with Alzheimer's disease or other dementia. The unit provides specialized programs, services and activities, and is locked, segregated or secured to provide or limit access by a resident outside the designated or separated area.
- 5 **Average Annual Per Diem Cost for Routine Services** is the average annual per diem cost for routine services for total allowable routine costs in accordance with applicable principles divided by total bed days.
- 6 **Bed Days** means the actual total occupied bed days for the year in accordance with applicable Principles of Reimbursement and including bed hold days for members, who because of need for medical care and/or visits with family or friends, are absent from the residence.
- 7 **Common Ownership** exists when an individual possesses significant ten percent (10%) ownership or equity in the provider and the institution or organization serving the provider.
- 8 **Control** exists where an individual or organization has the power, directly or indirectly to significantly influence or direct the actions or policies of an organization or institution.
- 9 **Cost of Capital** is the opportunity cost of all capital invested in an enterprise.
- 10 **Cost Reimbursement** is the term as used throughout these Principles that refers to the reimbursement methods established herein.
- 11 **Department** as used throughout these Principles refers to the State of Maine Department of Health and Human Services (DHHS).
- 12 **Discrete Costing** is the specific costing methodology that calculates the costs associated with new additions and/or renovations. In this methodology, none of the historical basis of costs from the original building is allocated to the addition/renovation.
- 13 **Discounts** as referred to in these Principles, are reductions granted for the settlement of debts.

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DEFINITIONS (cont.)

- 14 **Fair Market Value** is the price that the asset would bring as a result of bona fide bargaining between well-informed buyers and sellers as of the date of acquisition. Usually the fair market value price will be based on the price at which bona fide sales of assets of like type, quality and quantity have occurred, under similar market conditions in a particular market as of the date of acquisition. The Department's determination of the fair market value of the asset will be based on the lower of the sale price or the amount determined by an appraisal. The appraisal must be a full narrative appraisal report prepared by an appraiser who is licensed in the State of Maine and qualified to appraise residential care facilities. The appraisal must provide two components of the historical cost: the current reproduction cost, adjusted for depreciation from all sources, and the fair market value. The Department, at its discretion, may require an alternative appraisal. The submission of an appraisal by a facility indicates the facility's agreement with the appraisal, and shall preclude any challenge to the appraisal by the facility.
- 15 **Historical Cost**, for facilities transferred after July 1, 2001, is the maximum amount the Department will reimburse an owner to acquire any asset within the following four (4) asset categories within the facility, which shall comprise of: land, land improvements, buildings and moveable equipment. Acquired assets within each category shall be evaluated based on the following calculation methods (a., b., and c.). The Historical Cost of the facility shall be derived by adding the lowest of the three figures calculated within each asset category.
- a. Current reproduction cost adjusted for depreciation from all sources as of the date of acquisition by the buyer;
 - b. Fair market value as of the date of acquisition by the buyer;
 - c. The historical cost of the seller, inflated by the consumer price index for all items, the exception of moveable equipment, from the date or dates of acquisition or date placed into service.
- If there is no evaluation of the moveable equipment in accordance with a. or b. above, the net book value of the moveable equipment shall be its historical cost.
- 16 **Interest** is the cost incurred for the use of borrowed funds. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.
- 17 **Interim Payment Rate** means the per diem rate that the provider uses to bill the Department for eligible members. The interim payment rate will be used to calculate over or underpayments to the provider after the provider submits a report of actual operating expenses and financial statements and the Department completes an audit of the provider's records. A new interim payment rate is established for each fiscal period of the provider.
- 18 **Land (Non-Depreciable)** includes the land owned and used in provider operations. Included in the cost of the land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider and other land expenditures

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- of a non-depreciable nature. In the event a building is demolished, any remaining value, less demolition costs, would become part of non-depreciable land.
- 19 **Land Improvements (Depreciable)** include paving, tunnels, underpasses, onsite sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider.)
- 20 **Leasehold Improvements** include improvements and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.
- 21 **Licensed Capacity** as referenced in these Principles consists of the total licensed beds of a residential care facility times the number of days available in the fiscal period (e.g., a facility licensed for one hundred (100) residential care beds and open for a period of three hundred sixty-five (365) days, would have its licensed capacity stated at thirty-six thousand and five hundred (36,500) bed days.
- 22 **Licensed Residential Care Facility** as used throughout these Principles refers to those facilities currently licensed by the Department and reimbursed pursuant to these rules. The term is also synonymous with “facility” and “provider” as used in this document.
- 23 **Member** is an individual who meets the financial eligibility of the MaineCare program as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. Members must also meet medical eligibility criteria for specific services as set forth in the MaineCare Benefits Manual (MBM).
- 24 **Necessary and Proper Costs** are those that are appropriate in developing and maintaining the operation of residential care facilities and activities. They are costs which are common and accepted occurrences in the field of the provider’s activity.
- 25 **Necessary Interest** requires that the interest:
- a. Be incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments would not considered necessary.
 - b. Be reduced by investment income except where such income is from gifts, grants and endowments, whether restricted or unrestricted, and which are held separate and not comingled with other funds. Investment income from gifts, grants and endowments which are held separate and not comingled with other funds will be applied in accordance with Section 30.62. Additionally, income from funded depreciation is not used to reduce interest expense in accordance with Section 20.2.5.
- 26 **Net Book Value** of the asset is defined as the depreciable basis under the cost reimbursement program by the asset’s last participating owner, less the depreciation recognized under the program.

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- 27 **Occupancy Level** as referenced in these Principles consists of the sum of the total number of bed days of any bed in the facility is occupied divided by the licensed capacity.
(e.g., a facility open for a year, 12 months, 365 days, having and licensed for one hundred (100) residential care beds and having accrued 32,850 bed days in that period, would have its occupancy level at 90% of the licensed capacity. Thirty-two thousand eight-hundred and fifty divided by its licensed capacity stated at thirty-six thousand and five hundred (36,500) or 90% of licensed capacity.
- 28 **Owners** include any individual(s) or organization(s) with equity interest in the provider's operation and any members of such individual's family or his or her spouse's family. Owners also include all partners and all stockholders in the provider's operation and all partners and stockholders or organizations that have an equity interest in the provider's operation.
- 29 **Proper Interest** requires that interest:
- a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
 - b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.
 - c. Be reduced by investment income except where such income is from gifts, grants, and endowments, whether restricted or unrestricted, and which are held separate and not comingled with other funds. Investment income from gifts, grants and endowments which are held separate and not comingled with other funds will be applied in accordance with Section 30.6.2. Additionally, income from funded depreciation is not used to reduce interest expense in accordance with Section 20.2.5.
- Proper Interest**, as defined in 29, is subject to written prior approval as granted by the Division of Licensing and Certification before an expense is incurred. Retroactive approvals subsequent to an expenditure being incurred for energy efficient improvements, construction contingencies over five percent (5%), capital costs exceeding \$500,000, loan refinancings, and additional motor vehicles will not be granted.
- 30 **Reasonable Costs** are those incurred by a provider that are reasonable and necessary in providing adequate care to members eligible for cost-reimbursement and which are within the requirements and limitations of these Principles of Reimbursement. The reasonableness and necessity of any costs shall be determined by reference to, or in comparison with, the cost of providing comparable services.
- 31 **Refunds** are amounts paid back or a credit allowed due to an over collection.
- 32 **Related to the Provider** means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

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DEFINITIONS (cont.)

- 33 **State Seed** refers to the State general funds required for payments to the facility for room and board costs as well as the State general funds required to pay the State’s portion of Medical and Remedial Services costs, in accordance with Chapters II and III, Section 97 of the MBM.
- 34 **Straight-Line Method** of depreciation is when the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.
- 35 **Theoretical Level of Occupancy** is calculated at eighty percent (80%) for Level III residential care facilities and ninety percent (90%) for Level IV residential care facilities.
- 36 **Provider Agreement** encompasses the MaineCare Management Information System (MMIS) Provider/Supplier Agreement on file with the Office of MaineCare Services.
- 37 **Service Agreement** is a legally binding written document between DHHS Office of Aging and Disability Services (OADS) and a vendor for the provision of services to clients of DHHS OADS

10 **PURPOSE**

The purpose of these Principles is to comply with 22 Maine Revised Statutes Annotated, Section 10, namely: to provide for payment of room and board costs in residential care facilities through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically run facilities in order to provide room and board in conformity with applicable State and Federal laws, regulations, and quality and safety standards. The Department shall establish limits on cost components as a means of controlling costs and allocating funds.

10.1 **Scope**

These rules apply to Level III and Level IV residential care facilities or Private Non-Medical Institutions, who are eligible MaineCare Providers, as defined in Chapter 113 - Regulations Governing the Licensing and Functioning of Assisted Housing Programs

11 **AUTHORITY**

The authority of DHHS to accept and administer any funds that may be available from private, local, State, or Federal sources for the provision of the services set forth in these Principles of Reimbursement is established in Title 22 of the Maine Revised Statutes Annotated, §10 and §3173. The regulations are issued pursuant to authority granted to DHHS by Title 22 of the Maine Revised Statutes Annotated 42(1).

12 **RESPONSIBILITIES OF OWNERS OR OPERATORS**

The owners or operators of a residential care facility shall prudently manage and operate a residential health care program of adequate quality to meet its member’s needs. Neither the issuance of a per diem rate, nor final orders made by either the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a facility from full

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12 **RESPONSIBILITIES OF OWNERS OR OPERATORS** (cont.)

responsibility for compliance with the requirements and standards of DHHS or Federal government.

13 **DUTIES OF THE OWNER OR OPERATOR**

In order to qualify for reimbursement of allowable room and board costs, the owner or operator of a residential care facility, or a duly authorized representative shall:

13.1 Comply with the provisions of Section 12 of these Principles and be receiving payments for Medical and Remedial Services under the MaineCare program for eligible members.

13.2 Submit master file documents and cost reports in accordance with the provisions of these Principles.

13.3 Maintain adequate financial and statistical records and make them available when requested for inspection by an authorized representative of the Department, the State, or the Federal government.

13.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.

13.5 Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

13.6 Submit such data, statistics, schedules or other information the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the DHHS, Division of Audit, imposing the deficiency per diem rate described in Section 34.8 of these Principles.

14 **REIMBURSEMENT METHOD**

14.1 All facilities must be appropriately licensed by the Division of Licensing and Certification and have signed a Provider/Supplier Agreement with DHHS, Office of MaineCare Services, in order to be reimbursed.

14.2 Subject to the availability of funds, the Department will reimburse Appendix C and F, Level III and Level IV Private Non-Medical Institutions (PNMI) facilities defined under the MBM, Chapter III, Section 97, Appendix C and F for allowable room and board costs as defined in this Chapter.

14.3 Residential care facilities will be reimbursed for allowable room and board costs provided to eligible members based on an interim rate established by the Department.

The Department will establish an interim rate based on what it determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in conformity with applicable State and Federal laws, regulations and quality and safety standards.

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14 **REIMBURSEMENT METHOD (cont.)**

- 14.3.1 The Department will furnish blank cost reports to the facilities for their use. The facility's financial statements will be the basis for completing the cost report and establishing an interim rate of reimbursement.
- 14.3.2 Facilities are required to submit annual cost reports as stated in Section 18.4.
- 14.3.3 Written requests for interpretation of these Principles will be responded to in writing by the Department, and copies of these interpretation letters will be available to all interested parties.
- 14.3.4 In facilities licensed for nursing and residential care, the cost finding method contained in Section 18.3 of these Principles applies. All other Principles pertaining to the treatment of costs in these rules will also apply. Multi-level facilities must use the nursing facility cost report form.
- 14.3.5 The Department reserves the right to take legal action against, and/or terminate the MaineCare Provider/Supplier Agreement of a facility which fails to comply with these Principles, or which submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
- 14.3.6 The failure of the Department to insist upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these Principles, or to disapprove of any practice, accounting procedure or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be prevented from requiring such future performance.
- 14.3.7 No final audit shall be reopened, or any hearing allowed, concerning matters contained in any final audit if three (3) years following the date of the final audit settlement have passed. This limitation does not apply in the event of fraud or misrepresentation.

14.4 **Allowability of Costs**

If these Principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used, reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

15 **CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS**

- 15.1 Whenever a provider submits a cost report for audit that shows the facility was overpaid, the provider shall submit a check for one hundred percent (100%) of the overpayment with the cost report in order for the cost report to be accepted for audit.

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15 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS (cont.)

15.2 If, at the time the audit is completed, DHHS, Division of Audit, determines that the Department has underpaid a facility, the Department will pay the amount due and forward the result to the facility within thirty (30) days.

If the DHHS, Division of Audit, determines that the Department has overpaid a facility, DHHS, Division of Audit, will so notify the facility. Facilities will pay the total overpayment within ninety days of notice of the overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of its overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning ninety (90) days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

16 EFFECTIVE DATE

These Principles apply to reimbursement for room and board costs in residential care facilities beginning with dates of service on or after July 1, 2001.

17 COST RELATED TO CARE OF MEMBERS

17.1 Principle

Reimbursement for specified room and board costs shall be provided on a "reasonable cost-related basis" rather than by simply reimbursing the provider's costs. In determining what is a reasonable cost-related basis, all payments must relate to the care of the member and be based on the "reasonable cost." Reasonable costs include all allowable, necessary, and proper costs incurred in rendering room and board to members who are receiving Medical and Remedial Services under the MaineCare program, subject to the Principles relating to specific items of revenue and cost. Costs may not be shifted from Medical and Remedial Services to room and board.

17.1.1 Costs must be ordinary and necessary and related to member services. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

17.1.2 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under the principle that the substance of any transaction will prevail over form.

17.1.3 Costs that relate to inefficient, unnecessary or luxurious care of facilities (as defined by the Medicare Provider Reimbursement Manual, HIM-15), and to activities not common and accepted in the residential care field are not allowable.

17.1.4 Compensation, to be allowable, must be reasonable and for services that are necessary, and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The compensation must be reported to all appropriate state and federal tax authorities to the extent required

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17 **COST RELATED TO CARE OF MEMBERS** (cont.)

by law for income tax, social security, and unemployment insurance purposes. Reimbursement may not be claimed for personal expenses of the provider not related to member care. Bonuses that are part of a written policy of the provider and that require some measurable and attainable employee job performance expectations are allowable. Bonuses based solely on the availability of any anticipated savings are not allowable.

17.1.5 Costs incurred for room and board that are rendered in common to eligible members, as well as to ineligible members, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

17.1.6 Effective November 1, 2107, costs incurred by a residential care facility to comply with changes in federal or state laws, regulations, and rules or local ordinances and not otherwise specified in rules adopted by the Department are considered reasonable and necessary costs. Reimbursement for these additional regulatory costs will be paid via a supplemental payment that is added to the per diem rate until the Department adjusts for the routine limit, as applicable, to fairly and properly reimburse facilities for these costs.

Requests for rate adjustments must be made in writing and addressed to:

Director of Rate-Setting
11 State House Station
Augusta, ME 04333

The Department may deny or modify the adjustment request based on documentation provided and will provide written notification of adjustment request determination.

17.2 Room and Board Reimbursement Rate

17.2.1 The reimbursement rate will consist of a rate for routine services, and fixed/capital costs as defined in Principles 20 through 33. It will be offset by the program allowance received by the facility in accordance with the Principles of Reimbursement, Chapter III, Section 97, Appendices C and F.

17.2.2 The facility must account for and report all costs. To comply with the MaineCare requirements, the facility must segregate room and board costs from costs related to providing direct services in accordance with the Principles of Reimbursement, Chapter III, Section 97, Appendix C and F.

17.2.3 The Department will set interim per diem daily rates as follows:

Interim daily rates for Appendix C medical and remedial service facilities, and funded by DHHS, are set by the Office of Rate-Setting, DHHS.

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17 **COST RELATED TO CARE OF MEMBERS** (cont.)

Interim daily rates for Appendix F non-case mixed medical and remedial service facilities, funded by DHHS- Office of Aging and Disability Services, are set by the DHHS, Office of Rate-Setting .

18 **COST FINDING AND COST REPORTING**

18.1 **Cost Report Periods**

Facilities are required to submit annual cost reports, as prescribed herein, to the State of Maine, DHHS, Division of Audit, 11 State House Station, Augusta, Maine 04333-0011. Cost reports shall be based on the fiscal year of the facility.

18.2 **Accounting Principles**

Allowable costs shown in all cost reports described herein shall be on the basis of generally accepted accounting principles, except that facilities are allowed to file on the accrual, cash, or modified cash method of accounting. All new facilities are required to file on the Accrual basis. Once a facility has established an accounting method used in filing its annual cost report, that accounting method cannot be changed without the approval of the DHHS, Division of Audit. The provider must pay all year-end accruals within six (6) months after the end of the year in which the amounts are accrued. If the accruals are not paid within such time, these amounts will be deducted from allowable costs incurred in the first audit conducted following that six (6) month period.

18.3 **Cost Finding**

Total allowable costs shall be divided by the actual bed days to determine the cost per bed day. When facilities provide more than one level of care, including both nursing facility and residential care, total allowable costs shall be allocated to each level based on the occupancy data reported for each level and the following statistical bases:

18.3.1 **Capital Costs:** Square feet serviced to the extent the costs benefit both levels of care. In the event the cost benefits only one level of care, it will be directly costed to the level of care having the benefit of the cost.

18.3.2 **Plant Operation and Maintenance:** Square feet serviced.

18.3.3 **Housekeeping:** Lesser of actual direct cost or allocation based on square feet serviced.

18.3.4 **Laundry:** Pounds or resident days.

18.3.5 **Dietary:** Number of meals served.

18.3.6 **General and Administrative, Financial and Other Expenses:** Total accumulated allowable costs for each level of care, not including general and administrative and financial expense.

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18 **COST FINDING AND COST REPORTING (cont.)**

18.4 **Cost Reports**

- 18.4.1 **Forms:** Annual cost report forms provided by the DHHS, Division of Audit, shall be used for all facilities.
- 18.4.2 Each facility must submit an annual cost report on forms prescribed in Section 18.4.1. Cost reports and all supporting documentation requested are due within five months of the end of each fiscal year. Facilities are encouraged to submit a copy of the cost report on a computer disk in the format prescribed by DHHS, Division of Audit. Beginning July 1, 2002, all submissions must be made on electronic media to be specified by the Department. The inclusive dates of the reporting year shall be the twelve (12) month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director, DHHS, Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency in Section 34.8.
- 18.4.3 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.
- 18.4.4 **Certification by operator:** Each provider shall examine the cost report and supporting schedules prepared for submission to DHHS, Division of Audit, and shall certify that the report is a true, correct and complete statement prepared from the books and records of the provider.

The cost report is to be certified by the owner or operator of the facility. If someone other than the provider prepares the cost report, the person preparing the cost report must also sign that report.

18.5 **Record Keeping Requirements**

- 18.5.1 Providers must maintain an accounting system with accurate and auditable financial and statistical records that are in sufficient detail to substantiate their cost reports. The accounting system shall include original documents, journals, ledgers, trial balances, and financial statements. All records must be maintained for a period of not less than five (5) years following the date of final settlement.
- 18.5.2 These records shall include, but not be limited to, matters of provider ownership, organization, operation, fiscal and other record keeping systems, Federal and State income tax information, asset acquisition, lease, sale, or other action, franchise or management arrangement, member services charge schedule, matters pertaining to cost of operation, amounts of income received by service, and purpose and flow of funds and working capital.

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18.5.3 Providers shall make records available to representatives of the Department or the Maine Attorney General's Office. Providers shall be given at least a three (3) day notice when fiscal records are involved, and shall be notified which fiscal records are to be reviewed.

19 ADEQUACY AND TIMELINESS OF FILING

19.1 The cost report and financial statements for each facility shall be filed not later than five (5) months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, DHHS, Division of Audit, may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward, but reimbursement for the suspension period shall be at the deficiency rate as stated in Section 34.8.

19.2 The DHHS, Division of Audit, may reject any filing that does not comply with these Principles. In such case, the report shall be deemed not filed, until refiled and in compliance. No extension of time will be granted, other than those defined under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).

20 FIXED/CAPITAL COSTS

20.1 Fixed/Capital Costs include:

20.1.1 Depreciation on buildings, fixed equipment, land improvements, furnishings, moveable equipment, and amortization of leasehold improvements. The minimum dollar limitation on furnishings and moveable equipment that must be depreciated and treated as a fixed cost is three hundred dollars (\$300).

20.1.2 Interest expense attributed to debt associated with the acquisition or improvement of buildings, moveable equipment, furnishings, fixed equipment and land improvements.

20.1.3 Real estate taxes.

20.1.4 Fire insurance premiums.

20.1.5 In cases where facilities are rented from an unrelated party, the actual costs of ownership attributable to items in Sections 20.1.1, 20.1.2, 20.1.3 and 20.1.4 will be compared to the lease payments allowed under Principle 20.3.7(b). Except as provided in subparagraph 20.3.7(a)(3), return on equity is not included as a cost of ownership in the comparison.

20.1.6 Administrative allowance.

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20.1.7 The cost of Workers' Compensation Insurance (less the portion covered by MaineCare under Chapter III, Section 97, Appendix C or F of the MBM).

20.1.8 Water and sewer fees.

20.1.9 Amortization.

20.2 **Depreciation:** Allowance for depreciation based on asset costs.

20.2.1 **Principle** - An appropriate allowance for depreciation of buildings, moveable equipment, furnishings, and fixed equipment is an allowable cost. The depreciation must be:

20.2.1(a) Identified and recorded in the provider's accounting records.

20.2.1(b) In the case of donated (or inherited) assets, depreciation will be based on the lesser of the net book value of the asset, or the fair market value at the time of donation (or inheritance). Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or in testate distribution, (e.g. a widow inherits a residential care facility upon the death of her husband and becomes a newly certified provider) the basis of depreciation for the asset is the lesser of the fair market value, or the net book value of the asset in the hands of the owner last participating in the program. The basis for depreciation shall be determined as of the date of donation or the date of death, whichever is applicable.

20.2.1(c). In the event of a Federal or State grant or gift that is received for the purchase of property, which is not required to be paid back, then the basis of the property will be the cost, less the amount of the grant or gift.

20.2.1(d) Prorated over the estimated useful life of the asset using the straight-line method. Providers obtaining initial financing through tax-exempt bonds after January 1, 1991 may depreciate assets so financed over the life of the mortgage as long as it is no shorter than twenty (20) years. If this provision is applied, no component depreciation will be allowed and all assets so financed shall be depreciated on the same schedule.

20.2.1(e) Special Reimbursement Provisions for energy efficient improvements that include:

20.2.1(e)(1) For the energy efficient improvements listed below that are made to existing facilities, reimbursement will be allowed based on the length of the loan received, with the limitations listed below:

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Up to \$5000	Minimum depreciable period:	3 years
From \$5000.11 to \$10,000.99	Minimum depreciable period:	5 years
\$10,001.00 and over	Minimum depreciable period:	7 years

20.2.1(e)(2) The above limitations are minima and if a loan is obtained for a period of time in excess of these minima amounts, the depreciable period then becomes the length of the loan. In no case shall the depreciable period exceed the useful life, as stated in the Chart of Accounts published by the American Hospital Association.

20.2.1(e)(3) The reimbursement for the energy efficient improvements that are one hundred percent (100%) financed will consist of reimbursement of the principal and interest payments, based on the length of the loan or above listed minima. If no loans are obtained, then the depreciable lives will be based on the above minima. If only partially financed, then the interest and the principal payments will be reimbursed in addition to depreciation on the unfinanced amount according to the minimums spelled out above.

20.2.1(e)(4) Effective November 13, 2013, for an energy efficiency improvement to be reimbursable, the energy efficiency improvement must be recommended as a cost-effective energy efficiency improvement in an energy audit conducted by an independent energy audit firm, as evidenced in a written document, or must be determined to be cost-effective by the Efficiency Maine Trust, established in 35-A MRSA §10103, as evidenced in a written document.

20.2.1(e)(5) Reasonable energy efficient improvements may include:

- * Insulation (fiberglass, cellulose, etc.)
- * Energy efficient windows or doors for the outside of the facility, including insulating shades and shutters.
- * Caulking or weather stripping for windows or doors for the outside of the facility.
- * Fans specifically designed for circulation of heat inside the building.
- * Wood and coal burning furnaces or boilers (not fireplaces).

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- * Furnace replacement burners that reduce the amount of fuel used.
- * Regulating devices (i.e., Enetrol) or other devices connected to furnaces to control fuel used.
- * A device or capital expenditure for modifying an existing furnace that reduces the consumption of fuel.
- * Active solar systems for water and space heating.
- * Retrofitting structures for the purpose of creating or enhancing passive solar gain, must be prior approved by the Department regardless of amount of expenditure. A request for prior approval will be evaluated on the basis of whether energy costs would be decreased to such an extent as to render the expenditure reasonable. The age and condition of facility requesting approval will also be considered.
- * Any other energy saving devices that might qualify as energy efficient may be submitted for prior approval and they will be evaluated to determine that the energy savings device is reliable and sufficient energy cost reductions will be achieved.

20.2.1(e)(6) In the event of a sale of the facility; the principle payments, as listed above, will be recaptured in lieu of depreciation.

20.2.2 Recording of Depreciation: Prorating of the cost of an asset over its useful life is allowed on the straight-line method. Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation. The most recent edition of the "Estimated Useful Lives of Depreciable Hospital Assets" published by the American Hospital Association and publications of the Internal Revenue Service are to be used as guides for the estimation of the useful life of assets.

For new buildings, the minimum useful life to be assigned is:

20.2.2(a)	Wood Frame, Wood Exterior -	30 years
20.2.2(b)	Wood Frame, Masonry Exterior -	35 years
20.2.2(c)	Steel Frame, or Reinforced Concrete Masonry Exterior -	40 years

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If a mortgage obtained on the property exceeds the minimum life as listed above, then the terms of the mortgage will be used as the minimum useful life.

20.2.3 For facilities providing multiple levels of care, the allocation method to be used for allocating the interest, depreciation, property taxes, and insurance will be based on the actual square footage utilized in each level of care. However, when new construction occurs that is added on to an existing facility the complete allocation based on square footage will not be used. Discrete costing will be used to determine the cost of the portion of the building used for each level of care and the related fixed cost will be allocated on the basis of that cost.

20.2.4 Replacement Reserves: Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period in which they were set aside by the provider, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest and equity will apply.

20.2.4(a) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If for any reason the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets then during that year the allowable lease payment will be reduced by that amount. The lessee will be allowed to depreciate the assets purchased in this situation. However, if the premises are vacated before the improvements are fully depreciated, loss on disposal of the asset would not be reimbursable to the lessee.

20.2.4(b) If a rebate of a replacement reserve is returned to the lessee for any reason, it will be treated as a reduction of the allowable lease expense in the year review.

20.2.5 **Funding of Depreciation:** Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense or other costs.

20.2.6 **Gains and Losses on Disposal of Assets:** Gains and losses realized from the disposal of depreciable assets while a provider is participating in this program, or within one (1) year after leaving the program, are to be included in the determination of allowable cost. The extent to which such gains and losses are included is calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's

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participation in the program, and in the current period. For sales of facilities that occur on or after January 1, 2010, the Department shall either:

- (1) At the time of the sale, recapture depreciation paid by the Department under the MaineCare program, from the proceeds of the sale using the procedures outlined below;
 - (a) The recapture will be made in cash from the seller. During the first eight (8) years of operation, all depreciation allowed on buildings and fixed equipment by the Department will be recaptured from the seller in cash at the time of the sale. From the ninth (9th) to the fifteenth (15th) year all but three percent (3%) per year will be recaptured and from the sixteenth (16th) to the twenty-fifth (25th) year, all but eight percent (8%) per year will be recaptured, not to exceed one hundred percent (100%). Accumulated depreciation is recaptured to the extent of the gain on the sale.
 - (b) The buyer must demonstrate how the purchase price is allocated between depreciable and non-depreciable assets. The cost of land, building and equipment must be clearly documented. Unless there is a sales agreement specifically detailing each piece of moveable equipment, the gain on the sale will be determined by the total selling price of all moveable equipment compared to the book value at the time of the sale. No credits are allowed on moveable equipment.
 - (c) Accumulated depreciation is recaptured to the extent of the gain on the sale. In calculating the gain on the sale the entire purchase price will be compared to net book value unless the buyer demonstrates by an independent appraisal that a specific portion of the purchase price reflects the cost of non-depreciable assets.
 - (d) Depreciation will not be recaptured if depreciable assets are sold to a purchaser who will not use the assets for a health care service for which future Medicare, MaineCare, or State payments will be received. The purchaser must use the assets acquired within five (5) years of the purchase. The purchaser will be liable for recapture if the purchaser violates the provisions of this rule; OR
- (2) At the election of the buyer and seller, waive the recapture of depreciation at the time of the sale and allow the asset to transfer at the historical cost of the seller less depreciation allowed under the MaineCare program to the buyer for reimbursement purposes.

20.2.7 Limitation on the Participation of Capital Expenditures: The criteria for approval are the same as those found in Section 20.5.

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20.3 Purchase, Rental, Donation, and Lease of Capital Assets

20.3.1 When a facility is sold and then reacquired by the same seller, with no intervening transactions, the cost basis will be that recognized at the time of the first sale. Accumulated depreciation of the buyer shall be considered as incurred by the seller who reacquires the facility for the purpose of computing gains and applying the depreciation recapture rules (Section 20.2.6) to subsequent sales.

Since no step-up of depreciable assets is permitted, there will be no recapture at the time of reacquisition.

20.3.1(a) If a seller has extended a still outstanding loan to the buyer, and the seller reacquires possession after its sale, the cost basis will revert to what it would have been had the continued to own the facility. The amounts paid by the Department for interest on the increase in basis will be recaptured within six (6) months of reacquisition or at the time of resale, whichever occurs first. Depreciation originally recaptured by the Department shall be credited against the amount due the Department on any subsequent sale.

20.3.2 Purchase of Facilities from Related Individuals and/or Organizations

20.3.2(a) In the circumstances specified below, the purchaser's basis for depreciation shall not exceed the seller's basis under the program, less accumulated depreciation recognized under the program. Additionally, accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for the purpose of computing gains and applying the depreciation recapture rules (Section 20.2.6) to subsequent sales by the buyer. Since no step-up in the basis of depreciable assets is permitted to the buyer, there will be no recapture of depreciation from the related party seller on a sale. These provisions apply:

20.3.2(a)(1) Where a facility is purchased from an individual or organization related to the purchaser by common control and/or ownership; or

20.3.2(a)(2) Where a facility is purchased after March 1, 1990, by an individual related to the seller as:

- (i) a child,
- (ii) a grandchild,
- (iii) a brother or sister,

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(iv) a spouse of a child, grandchild, or brother or sister, or

(v) an organizational entity controlled by a child, grandchild, brother, sister or spouse of child, grandchild or brother or sister thereof; or some combination of the above.

20.3.2(a)(3) Where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller are entities related by Section 20.3.2 (a)(1) or Section 20.3.2(a)(2) above.

20.3.2(b) At the election of the seller, Section 20.3.2 (a) will not apply to a sale made to a buyer defined in Section 20.3.2 (a)(2), as an exception, if:

20.3.2(b)(1) The seller is an individual or an entity owned or controlled by individuals or related individuals who were selling assets to a related party, as defined in Section 20.3.2 (a)(2);

20.3.2(b)(2) The seller has attained the age of fifty-five (55) before the date of the sale or exchange;

20.3.2(b)(3) During the twenty-year (20) period ending on the day of the sale, the seller has owned or operated the facility for periods aggregating ten (10) years or more, or the seller has inherited the facility as property of a deceased spouse to satisfy the holding requirements; and

20.3.2(b)(4) If the seller makes a valid election to be exempted from the application of 20.3.2, the allowable basis of depreciable assets for reimbursement of interest and depreciation expense to the buyer will be determined in accordance with the historical cost as though the parties were not related. This transaction is subject to depreciation recapture if there is a gain on the sale.

20.3.2(c) The exception listed in 20.3.2(b) can be applied to all facilities owned by the same seller.

20.3.3 **Basis of Assets Used and Donated to a Provider:** When an asset which has been used or depreciated under cost reimbursement is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the last participating owner. The

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net book value of the asset is defined as the depreciable basis used by the asset's last participating owner less the depreciation recognized.

20.3.4 **Allowance for Depreciation on Assets Financed with Federal or State Funds:** Depreciation is allowed on assets financed with Hill Burton or other Federal or State funds, only to the extent that repayments are required. Facilities with Federal or State rental subsidies that offset a provider's interest and principal payments may not claim depreciation expense on those same assets.

20.3.5 **Rental Expense Paid to an Organization Related to the Provider:** A provider may lease a facility from an organization related to the provider by common ownership or control within the meaning of the Principles of Reimbursement. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its costs the costs of ownership of the facility. These costs are depreciation, interest on the mortgage, real estate taxes and other expenses that would otherwise be allowable room and board costs, and are attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider.

20.3.6 **Sale and Leaseback Agreements - Rental Charges:** Rental costs specified in sale and leaseback agreements incurred by providers through selling physical plant facilities or equipment to a purchaser not connected with or related to the provider, and concurrently leasing back the same facilities or equipment, are included in allowable cost if these conditions are met:

20.3.6(a) The rental charges are reasonable based on consideration of rental charges for comparable facilities and market conditions in the area, the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements; and

20.3.6(b) Adequate alternate facilities or equipment are not or were not available at lower cost.

20.3.7 **Leases, Capitalized Leases, and Limited Partnerships**

20.3.7(a) To be an allowable cost, lease payments must:

20.3.7(a)(1) be pursuant to a lease between parties not related by common ownership and control; and

20.3.7(a)(2) not exceed the annual cost that would be allowed under these Principles if the lessee owned the facility and return on owner's equity was not included in calculating the owner's cost.

20.3.7(a)(3) if the lease agreement was in effect prior to July 1, 2003, not exceed the annual cost that would be

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allowed under these Principles if the lessee owned the facility and return on owner's equity was included in calculating the owner's cost. All of the following criteria must be met:

- i. the calculation of the owner's cost does not include interest;
- ii. the provider remains legally obligated to pay the lease amount;
- iii. the lease agreement has not been amended or modified after July 1, 2003;
- iv. the lessor must be a Real Estate Investment Trust (REIT); and
- v. the rate of the return on owner's equity will not exceed eight percent (8%) or the lessor's cost of capital, whichever is less.

20.3.7(b) In lease arrangements between individuals or organizations not related by common control or ownership, the allowable cost between two (2) unrelated organizations is the lesser of:

20.3.7(b)(1) Except as provided in subparagraph 20.3.7(a)(3), the actual costs of ownership as defined in Principle 20.1.5; or

20.3.7(b)(2) the actual lease payments made by the lessee to the lessor.

20.3.7(c) If the actual lease payments are less than the actual cost of ownership, then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, the lease costs exceed the cost of ownership, the deferred cost may begin to be amortized. Amortization will increase allowable costs up to the level of the actual lease payments for any given year. These deferred costs are not assets of the provider for purposes of calculating allowable costs of interest or return of owners' equity and, except as specified, do not represent assets that a provider or creditor of a provider may claim as a monetary obligation from the program.

20.3.7(d) **Limited Partnerships:** When a lessee participates as a limited partner in the lessor's partnership, the rules regarding related organizations set forth in Section 20.3.5 shall apply.

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20.3.7(e) **Recapture of Depreciation:** In order for lease or rent payments to be an allowable cost in a non-related party transaction, the owner of the asset who incurs the depreciation expense is generally responsible for repayment of the accumulated depreciation expense. Recapture under approved lease agreements will be limited to depreciation expense on buildings and fixed equipment. Any depreciation expense for leasehold improvements or on any other depreciable asset owned by the lessee shall be recaptured pursuant to Section 20.2.6. In related party leases, the asset will be treated as if owned by the lessee, and recapture will be made in accordance with Section 20.2.6. Whenever rent or lease payments are allowed there shall be a written guarantee for repayment between the lessor, lessee and the Department. Failure of the lessee to secure such an agreement will result in the disallowance of costs representing depreciation. The amount of recapture pursuant to a lease agreement will be calculated in accordance with Section 20.2.6.

20.3.7(f) Capitalized leases shall not be allowed.

20.3.7(g) **Historical Cost:** If the facility is sold to be used as a residential care facility or nursing care facility, the historical cost of the new owner will be determined in the manner defined in the Definition section.

20.3.8 When a facility is purchased from a seller who has been terminated from the MaineCare program by the Department because of a criminal conviction and the conviction is related to violation of these Principles or the Department's applicable licensing regulations, including but not limited, to conviction under Title 17-A of the Maine Revised Statutes Annotated or Title 22, Section 47 of those statutes, the basis for depreciation for the purchaser will be that of the seller under the program.

20.4 **Interest Expense on Indebtedness**

20.4.1 Necessary and proper interest on both current and capital indebtedness is an allowable cost.

20.4.2 **Interest:** Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses.

Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities, fixed and moveable equipment, capital improvements, and vehicles. Generally, loans for capital purposes are long-term loans. Except as provided in subsection 20.4.7, interest does not include interest and penalties charged for failure to pay accounts when due.

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20.4.3 **Necessary:** In order to be considered “necessary”, interest must be:

20.4.3(a) incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would be considered unnecessary; and

20.4.3(b) reduced by investment income except where such income is from gifts, grants and endowments, whether restricted or unrestricted, and which are held separate and not commingled with other funds.

Investment income from gifts, grants and endowments which are held separate and not comingled with other funds will be applied in accordance with Section 30.6.2. Income from funded depreciation is not used to reduce interest expense.

20.4.3(c) Proper requires that interest:

(i.) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(ii) Interest payments are due for a period of time not to exceed the remaining useful life of the items, pursuant to 20.2.2 herein, to be purchased or, in the case of refinancing a current loan, the underlying asset that the original loan was taken out to purchase.

(iii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.

20.4.3(d) approved for refinancing. Any refinancing of property mortgages or loans on fixed assets must be prior approved in writing by the Department’s Division of Licensing and Certification, prior to the closing of the loan. If written prior approval is not obtained the Department will pay the lowest of the following;

1. The actual interest paid, or

2. The amount of interest the provider would have paid in the current fiscal year, under the terms of the original loan. Original loan means the last department approved loan.

(A) If the original loan had a variable rate, the last variable rate will be the rate that is utilized throughout the term of the refinanced loan. If the original loan had a fixed rate, that will be the rate utilized throughout the term of the refinanced loan.

(B) Closing costs for a refinanced loan are not allowed.

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The Department may condition refinancing approvals.

The Department will not pay for swap investments. Swap investment is defined as an interest rate swap agreement between two counterparties in which one stream of future interest payments is exchanged for another, based on a specified principal amount.

20.4.4 Borrower - Lender Relationship

20.4.4(a) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the “bargaining” process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm’s length transactions with lending institutions. The Division of Licensing and Certification shall make the determination for written prior approvals. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable.

20.4.4(b) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. When the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

20.4.4(c) When funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to member care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

20.4.5 Loans Not Reasonably Related to Member Care: Loans made to finance that portion of the cost of acquisition of a facility that exceeds the amount approved by the Department as the provider’s historical cost are not considered to be for a purpose reasonably related to member care.

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- 20.4.6 **Interest Expense of Related Organizations:** When a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as a cost, costs of ownership of the leased facility are allowable costs of the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider.
- 20.4.7 **Interest on Property Taxes:** Interest charged by a municipality for late payment of property taxes is an allowable cost when the following conditions have been met:
- 20.4.7(a) The rate of interest charged by the municipality is less than the interest that a prudent borrower would have had to pay in the money market existing at the time the loan was made;
- 20.4.7(b) The payment of property taxes is deferred under an arrangement acceptable to the municipality;
- 20.4.7(c) The late payment of property taxes results from the financial needs of the provider and does not result in excess funds.
- 20.4.8 **Interest on Construction Loans:** Construction interest incurred as part of an approved capital budget to make approved capital improvements (new construction, acquisitions, or renovations) is allowable only during the approved construction period and up to sixty (60) days after the completion date of the approved capital improvements. The Department shall determine the completion date.

20.5 **New Construction, Acquisitions and Renovations**

Effective November 1, 2017, for all proposed new construction, acquisitions or renovations involving capital expenditures, in the aggregate, that exceed Five Hundred Thousand Dollars (\$500,000) or more in one (1) fiscal year, providers must submit plans, financial proposals, and projected operating costs to the

Department for written prior approval in order for costs to be reimbursed. A provider shall not separate costs into components, such as land, land improvements, buildings, building improvements, or moveable equipment, to evade the cost limitations that require prior approval. Effective November 1, 2017, capital expenditures for energy efficiency improvements, for replacement equipment, for information systems, for communications systems and for parking lots and garages are permitted without written prior approval; these expenditures shall be excluded from the \$500,000 threshold referenced herein. These written requests are reviewed by Licensing and Certification. See Principle 20.2.1(e).

Decisions will be made based on the following criteria:

- 20.5.1 Members in the facility demonstrate a need for the service;
- 20.5.2 Less costly alternatives or more effective methods of providing the services are not available;

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- 20.5.3 The service is required by the licensing regulations;
- 20.5.4 Costs are reasonable, including pre-development, construction and financing costs;
- 20.5.5 The improvement will add considerably to the useful life of the asset;
- 20.5.6 If the application is for reimbursement of costs associated with additional beds, the facility must be in compliance with any rules and the statute covering the approval of additional beds, 22 MRS §§ 333 through 334-A as approved by the Division of Licensing and Certification.
- 20.5.7 Funds are available to reimburse the facility for applicable expenses.
- 20.5.8 Design and construction standards applicable to projects reviewed by the Department include, but are not limited to, the following:
 - 20.5.8(a) **Building Area Requirements.** Gross building area, which shall include all living area as well as all support area such as the mechanical room, shall not exceed five hundred (500) square feet per licensed bed without justification of need.
 - 20.5.8(b) **Land and Land Improvements.** Only the minimum amount of land necessary to satisfy local requirements, if applicable, or to situate the building and provide adequate parking will be allowed. The Department will not reimburse the cost of any land improvement, such as a gazebo, which it determines to be either unnecessary or extravagant. Land and land improvement costs must be supported by comparative cost information to confirm that the costs are reasonable and necessary.
 - 20.5.8(c) **Architectural and Engineering Fees.** Fees that exceed the *State of Maine Recommended Fee Schedule for Public Buildings* (current edition) will not be allowed without Department approval.
 - 20.5.8(d) **Construction Contingency.** Construction Contingency shall not exceed five percent (5%) of the construction budget, which shall be net of any subcontractor contingency fees. If the Department determines that a larger contingency is justified, the fee may increase to a maximum of eight percent (8%) of the construction budget. The contingency may not be used without written prior approval of the Division that approved the construction and the Division of Licensing and Certification.
 - 20.5.8(e) **Developer and Marketing Fees.** Developer and marketing fees will not be allowed.

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- 20.5.8(f) **Moveable Equipment.** Moveable equipment, excluding computers, printers, and networking, shall not exceed five thousand dollars (\$5,000) per licensed bed. The Department will not reimburse the cost of any moveable equipment, such as televisions in resident rooms, which it determines to be not necessary for resident care.
- 20.5.8(g) **Computer System.** Only computer hardware may be considered a capital cost; the Department will not consider software purchase or upgrades as an allowable capital expenditure. The computer system must be described in detail and include a description of the system's functionality, which must justify the system's cost.
- 20.5.8(h) **Construction Cost per Square Foot.** The calculation of the construction cost per square foot shall include land improvement cost, architect/engineering fees, construction supervision, building construction cost, other design/consultant costs related to the construction, insurance during construction, municipal permits, and interest during construction. Construction cost per square foot shall be compared, for reasonableness, to the Calculator and Segregated Cost methods in the Marshall Valuation Service cost estimating manual.

20.6 **Administration and Management Allowance**

- 20.6.1 An administration and policy-planning allowance shall be permitted in lieu any other compensation for the administration and policy planning functions and in lieu of all fees for management or financial consultants. Compensation includes all fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy planning services. Compensation also includes the cost of food, lodging, use of the provider's vehicles and other services supplied by the provider that benefit those carrying out the administrative and policy planning services. Outside accounting fees associated with preparation of financial reports required by the DHHS, Division of Audit are not included in the allowance but are allowed as a routine cost. The administrator is not entitled to reimbursement for any other services performed for the facility, including but not limited to direct care, cooking, and bookkeeping, even if the administrator is not the owner of the facility, unless the facility qualifies for a waiver of this principle as set forth below.

A facility with six (6) or fewer beds may request a waiver of the above principle by submitting a written application for waiver to the Director, DHHS, Division of Audit. The facility's application shall describe other services to be performed, the rate of pay for these other services, the hours to be spent performing such other services and the facility's operational need to have such other services performed. The facility must obtain the written approval of the Director, DHHS, Division of Audit, prior to such services being performed and in advance of claiming reimbursement. In addition, the facility must submit evidence such as

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time studies with the cost report to prove that such other services were actually rendered to the facility. Such other service costs will be reconciled at cost settlement in accordance with the Director's written approval and applicable cost settlement principles.

In the event the Department determines that the administrator has delegated significant responsibilities, such as described in this section and under Section 10 of the Regulations Governing the Licensing and Functioning of Assisted Living Facilities -IV, allocation of wages from routine services to the administrative allowance will be made.

- 20.6.2 The allowance is the calculation of the administrative and policy planning allowance for an administrator who is responsible for only one (1) facility and is based on the total number of licensed beds in that facility. The following table, effective July 1, 2001, for fiscal year ending June 30, 2002, reflects the allowance for an administrator who is responsible for one facility. To the extent that funds are available, the Commissioner of DHHS may, at his or her discretion, determine if an inflation adjustment will be made.

Total Beds	Allowance
3 to 10 beds	\$22,382 plus \$1,085 for each bed in excess of 3.
11 to 30 beds	\$29,985 plus \$566 for each bed in excess of 10.
31 to 50 beds	\$41,372 plus \$290 for each bed in excess of 30.
51 to 100 beds	\$47,133 plus \$153 for each bed in excess of 50.
Over 100 beds	\$54,774 plus \$84 for each bed in excess of 100.

- 20.6.3 When the individual is designated as administrator, for more than one (1) facility, several factors are considered in the calculation of the allowances for each facility. If the facilities are located on separate sites, the combined number of beds will be used and applied to one hundred and twenty percent (120%) of the above schedule. The total allowance will be prorated to the facilities based on the ratio of each facility's number of beds to the combined number of beds for all facilities under the direction of the administrator.
- 20.6.4 If the facilities or levels of care are located on the same site, the total allowance corresponding to the combined number of beds will be prorated to the facilities based on the ratio of each facility's number of beds to the combined number of beds for all facilities or levels of care under the direction of the administrator.
- 20.6.5 In the instances where there is a shared administrator for both the nursing and residential facility levels of care, the administrative and management allowance will be calculated using the total number of beds (for which the administrator is responsible) in the facility on the nursing care administrative allowance schedule less two hundred dollars (\$200) per licensed residential care bed. The

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Department recognizes that accounting fees are included as part of the administrative allowance for nursing facilities and are also utilized in determining the routine cap on service costs for all residential care facilities.

However, the Department has determined that the deduction of two hundred dollars (\$200) per licensed residential care bed will offset this factor.

20.6.6 In instances where there is a shared administrator for nursing facility, and/or residential care, and/or congregate housing services programs, the administrative and management allowance will be calculated using the total number of beds/units (for which the administrator is responsible) in the facility on the nursing care administrative allowance schedule less two hundred dollars (\$200) per licensed residential care bed and congregate housing unit.

20.6.7 In instances where there is a shared administrator for residential care and/or congregate housing services programs, the administrative and management allowance will be calculated using the total number of beds/units (for which the administrator is responsible) in the facility on the residential care administrative allowance schedule less two hundred dollars (\$200) per licensed congregate housing unit.

20.6.8 For facilities of six (6) or fewer beds with a shared administrator, each six (6) bed facility shall be allowed an administrative allowance according to the above schedule.

20.6.9 When the owner of the residential care facility is also the administrator, only one (1) administrative allowance/salary shall be permitted. In instances where the owner/administrator is also the employed administrator for another residential care facility(ies) that he/she neither owns nor has a financial interest in, the two (2) situations shall be considered as completely separate entities, upon prior approval by the Department.

20.7 Administrative Functions

The administrative function includes those duties that are necessary to the general supervision and direction of the current operations of the facility, including, but not limited to the following:

20.7.0(a) Administration of the policies of the facility.

20.7.0(b) Day to day operation and management.

20.7.0(c) Control, conversion and utilization of the physical and financial aspects.
Obtaining adequate personnel.

20.7.0(d) Discharge of such functions as the licensee may be properly delegated.

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- 20.7.0(e) Completion of any duties/responsibilities described by the applicable licensing regulations as being the responsibility of the administrator.
- 20.7.0(f) Administrators, assistant administrators, business managers, controllers, office managers, personnel directors, and purchasing agents, personal secretaries to any of the above, typify those who are included in the administrative function category. Bookkeepers, secretaries, clerks, telephone operators, etc., are not included in this category.
- 20.7.0(g) This allowance is not to include those individuals whose prime duties are not of an administrative nature, who may be responsible for hiring or purchasing for their department.
- 20.7.0(h) **Policy-planning functions.** The policy-planning function includes the policy-making, planning, and decision-making activities necessary for the general and long term management of the affairs of the facility, including, but not limited to the following:
 - 20.7.0(h)(1) The financial management of the facility.
 - 20.7.0(h)(2) The establishment of personnel policies.
 - 20.7.0(h)(3) The planning of expansion and financing thereof.
- 20.7.0(i) For purposes of these rules, owners include any individual or organization with equity interest in the provider's operation and any members of such individual's family or his or her spouse's family. Owners also include all partners and all stockholders in the provider's operation and all partners and stockholders or organizations that have an equity interest in the provider's operation.

21 **WORKERS' COMPENSATION**

Workers' Compensation insurance premiums to cover staff who provide room and board services, paid to an admitted carrier, applicable fees, assessments and premiums paid to an authorized and fully funded trust, and premiums paid to an individual self-insured program approved by the State of Maine, are fixed/capital costs. Capital contributions are not an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of Workers' Compensation insurance. In those instances where the Department finds that a facility pays more than the going rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under these Principles. That portion of any Workers' Compensation insurance premium paid for the benefit of the administrator of the facility shall be allowed as part of the total cost of the premium and shall not be deducted in lieu of the administrative allowance.

22 **WATER AND SEWER FEES**

Fees assessed for water and sewer usage, as well as connection costs that are assessed by a municipality, are allowable fixed costs.

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23 **AMORTIZATION**

- 23.1 **General.** Prior to admitting members, certain costs are incurred, which are referred to as start-up costs. These costs must be capitalized as deferred charges and amortized over a period of sixty (60) consecutive months, beginning with the first month members are admitted. Start-up costs include, for example, routine and direct service salaries, payroll taxes and fringe benefits, heat, gas, electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incident to the start-up period.
- 23.2 Costs that are properly identifiable as organization costs, or which may be capitalized as construction costs must be appropriately classified as such and excluded from start-up costs.
- 23.2.1 Legal fees paid for organizational expenses are to be amortized over a sixty (60) month period.

30 **ROUTINE COSTS**

30.1 **Allowable Costs**

Routine costs are those items of expense that providers must incur in order to provide room and board to members receiving medical and remedial services, providing the sum of the expenses, in whole or in part, are reasonable and necessary. Allowable routine costs include:

- 30.1.1 Maintenance wages, payroll taxes and fringe benefits.
- 30.1.2 Other room and board expenses, such as food and supplies (except medical supplies), fuels for heating and cooking, towels, linens, costs associated with repairs and maintenance, insurance (other than fire), utilities (except water and sewer) and electricity.
- 30.1.3 General and administrative costs, excluding the administrative allowance which is part of the fixed/capital component, but including reasonable support costs. Examples of allowable general and administrative costs include telephone, dues and subscriptions, vehicle or transportation costs (other than interest and depreciation), office supplies, legal and accounting, bookkeeping, software and associated ongoing support costs, and interest on current indebtedness.
- 30.1.4 Allowable costs shall also include the following taxes and benefits applicable to routine service staff: payroll taxes, unemployment, health insurance, dental insurance, employer term life/disability insurance, and qualified retirement contributions.
- 30.1.5 The PNMI's facility-specific routine services rate will be reduced by the actual amount of wages, taxes, and benefits of laundry, housekeeping, and dietary direct services covered under Section 97, PNMI Services as of July 1, 2002.

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30 **ROUTINE COSTS (cont.)**

For a new facility, the routine component will initially be determined by including all laundry, housekeeping and dietary direct service wages, taxes and benefits and applying those costs against the routine upper limit. Once the laundry, housekeeping and dietary direct service costs are removed, the routine rate will be reduced accordingly.

- 30.1.6 Effective August 1, 2018, for the state fiscal year ending June 30, 2019, a special supplemental allowance must be made to Appendix C PNMI's to provide for increases in wages and wage-related benefits in the routine cost component. An amount equal to ten percent (10%) of wages and associated benefits and taxes in the routine cost component as reported on each facility's as-filed cost report for its fiscal year ending in calendar year 2016 must be added to the cost per resident day in calculating each facility's prospective rate, notwithstanding any otherwise applicable caps or limits on reimbursement. This supplemental allowance must also be allowed and paid at final audit to the full extent that it does not cause reimbursement to exceed the facility's allowable cost per day in the routine cost component in that fiscal year.

30.2 **Interest**

Interest on current indebtedness is an allowable routine cost. Interest on working capital loans for normal operating expenses is allowable provided the funds are borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. Interest must be necessary and proper as defined in Section 20.4. Allowable interest does not include interest and penalties charged for failure to pay accounts when due.

30.3 **Bad Debts, Charity, and Courtesy Allowance**

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs.

30.4 **Cost of Educational Activities**

- 30.4.1 Orientation, on-the-job training, in-service education and similar instruction are recognized as normal routine costs when related to room and board (routine costs). Reasonable registration fees and transportation costs of relevant in-state training programs are allowed if included as employee benefits in a written personnel policy. The cost of relief staff to replace employees whose wages are considered room and board are also an allowable routine cost. Costs associated with out-of-state training programs are not allowed as room and board costs.

- 30.4.1(a) Orientation is training provided to new employees who provide room and board services to acquaint them with the facility's philosophy, goals, organization, programs, and practices, and to familiarize new employees with the tasks they will be expected to perform.

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- 30.4.1(b) On-the-Job Training is competency-based hands-on training provided to new employees who provide room and board to teach and enhance skills related to the performance of their duties.

- 30.4.1(c) In-service education and similar instruction is an organized educational program for updating, maintaining, and improving employees' skills and competencies, and is based on the expressed job-related needs of the employees who provide room and board services.

30.5 **Research Costs**

Costs that are incurred for research purposes over and above usual provision of room and board to members are not an allowable routine cost.

30.6 **Grants, Gifts, and Income from Endowments**

- 30.6.1 Gifts, grants, or endowment income designated by a donor for paying specific room and board or operating costs shall be deducted from the particular operating cost or group of costs. Any portion to the above cited grants or gifts will not be offset until such time as it is used. Unrestricted Federal or State grants or gifts received by a facility, without designation for their usage, will be used to reduce the total operating costs of the facility.

- 30.6.2 All (gross) investment income (not net investment income) from unrestricted grants, gifts or endowment funds will be used first to offset any differential between the facility's room and board rate and its room and board costs, up to the Departmental upper limit on routine services. Any remaining investment income shall then be used to reduce interest expense.
 - 30.6.2(a) Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to the provider without restriction by the donor as to their use.

 - 30.6.2(b) Designated or restricted grants, gifts, and income from endowments are funds, cash or otherwise, which must be used only for the specific purpose designated by the donor.

30.7 **Life Contracts**

The Department will not participate in the cost of providing room and board to members in non-profit facilities whose care is covered by negotiated life contracts. The term life contract means a negotiated agreement that commits a facility to provide care for an individual for the remainder of that person's life.

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30 **ROUTINE COSTS** (cont.)

30.8 **Unrestricted Income**

Unrestricted income from sources such as unrestricted grants, gifts, or endowments are expected to be used to improve the quality of the environment and services to the member. The unrestricted income will be used to decrease the total operating costs of the facility.

30.9 **Donations of Produce or Other Supplies**

Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include that cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included shall be deleted in determining allowable costs.

30.10 **Donation of Use of Space**

A provider may receive a donation of the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use of the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's cost, the amount included shall be deleted in determining allowable costs.

30.11 **EXTRAORDINARY CIRCUMSTANCE ALLOWANCE**

Effective November 1, 2017, facilities which experience unforeseen and uncontrollable events during a year that result in unforeseen or uncontrollable increases in routine cost expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance (ECA).

Unforeseen means that a provider did not have sufficient notice of the change to make changes to their business plan.

Uncontrollable means that the event occurred as a result of forces outside the provider's organization. Business decisions are not considered uncontrollable.

Extraordinary circumstances may include, but are not limited to:

- * events of a catastrophic nature (fire, flood, etc.);
- * unforeseen increase in minimum wage, Social Security, or employee retirement contribution expenses in lieu of Social Security expenses;
- * changes in the number of licensed beds, which excludes any requests by providers to change licensed beds;
- * changes in licensure or accreditation requirements.

If the Department concludes that an extraordinary circumstance existed, and the increased routine costs are considered reasonable and necessary, and an adjustment will be made by the Department in the form of a supplemental allowance.

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30 **ROUTINE COSTS** (cont.)

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year. Reimbursement to a residential care facility for additional routine costs arising from extraordinary circumstance must be paid via a supplemental payment that is added to the per diem reimbursement rate until the Department adjusts the routine limit, as applicable, to fairly and properly reimburse a facility for these costs.

A request for an ECA must be made in writing and addressed to:

Department of Health and Human Services
Director of Rate-Setting
11 State House Station
Augusta, ME 04333

The written request must include:

1. The reason(s) for the ECA request;
2. The dollar amount of the ECA request;
3. The expected/anticipated duration of the need for the ECA;
4. An explanation of how the ECA request is both unforeseen and uncontrollable; and
5. All documentation supporting the ECA request.

The Department may require additional documentation to review and process the ECA request. A facility requesting an ECA shall provide all documents requested by the Department. The Department shall deny any ECA requests from facilities who refuse to supply requested documentation.

31 **OTHER ALLOWABLE ROUTINE COSTS**

31.1 **Purchase Discounts and Allowances, and Refunds of Expenses**

31.1.1(a) Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

31.1.2(b) **Reduction of Costs.** All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the comparable purchases or expenses in the period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

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31 **OTHER ALLOWABLE ROUTINE COSTS (cont.)**

31.1.3(c) **Application**

31.1.3(c)(1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms.

Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

31.1.3(c)(2) All discounts, allowances, and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is generally followed by other governmental programs and third-party payment organizations that pay on the basis of cost.

31.2 **Advertising Expenses**

The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

31.3 **Income**

31.3.1(a) All unrestricted income other than from members, except as specified in Section 30.6, received by facilities and that can be used in the overall operation of the facility will be used to decrease the total operating costs. This includes income from vending machines, sales of meals, sale of medical supplies, Federal or State grants or gifts, rental of facility space, etc. When restricted grants, gifts, or endowments are made to cover any of the overall operating costs, income from these shall be used to offset the respective costs. If the Department discovers that the income is not large enough to cover the expenses of rentals, meals, etc., then the expense, instead of income, will be removed from the total costs. The provider also has the right to remove from allowable costs the expenses, instead of the income, if they can be completely segregated from other expenses.

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31.4 Cost to Related Organizations

31.4.1(a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

31.4.2(b) If any owner, other than the administrator, provides non-administrative services to the provider, the compensation for such services shall be allowed only after the Department has given advance written approval.

31.5 Motor Vehicle Allowance

31.5.1(a) The cost of operating one (1) motor vehicle necessary to meet the needs of the facility is an allowable cost, less the portion of usage of that vehicle that is considered personal. Allowable routine costs include insurance and reasonable operating expenses.

31.5.1(b) Costs for any additional vehicles must be requested in writing and prior approved in writing by the Department's Division of Licensing and Certification. Criteria for approval will include the number of members, effective utilization of the existing vehicle, and the reasonableness and practicality of the type/size of the additional vehicle requested.

31.6 Insurance

31.6.1(a) Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs. Hospital insurance premiums paid on employees are an allowable cost, if reasonable.

31.6.1(b) Life insurance premiums related to insurance on the lives of officers and key employees when the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary when, upon death of the insured officer or key employee, the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer, the proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because he/she does not receive the proceeds directly, but is, nonetheless, an indirect beneficiary, since his/her liability on the loan is reduced.

31.6.1(c) Premiums paid to insure property not used or required for care of members is not allowed.

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31.7 **Legal Fees**

In order for legal fees to be allowable costs, they must be directly related to member care. Fees paid to the attorneys for representation against the Department are not allowable costs. Retainers paid to lawyers are not allowable costs.

32 **INDIRECT COST ALLOCATION**

Indirect costs are those that are incurred for common or joint objectives, and are not considered direct costs. They shall be pooled and distributed to the individual services or programs benefiting therefrom. The overall objective of the indirect cost allocation process is to provide a reasonable and comparable distribution of the indirect costs of an agency with multiple programs to its various activities or cost objectives. Allowable indirect costs shall be allocated to the following rate components: routine costs and fixed/capital costs. The distribution of indirect costs shall be in compliance with generally accepted accounting methods and shall have been approved by the DHHS, Division of Audit.

33 **PROGRAM ALLOWANCE**

Facilities enrolled as a MaineCare Provider and have a MaineCare Provider/Supplier Agreement, and who are paid under Chapters II and III, Section 97, Appendices C or F, shall receive a program allowance from MaineCare that allows the Department to receive Federal matching funds for certain unspecified routine costs that also support the provision of MaineCare-covered services. Routine services costs will be offset by the amount of the MaineCare program allowance multiplied by the total resident days. The program allowance will be set at a minimum of ten percent (10%) or at a maximum determined at the discretion of the Commissioner of the applicable agency providing the State share of MaineCare reimbursement, depending on the extent of funds available. The maximum reimbursement amount allowed including the program allowance will not be greater than the total room and board costs.

34 **METHOD OF PAYMENT**

34.1 **Per Diem Costs**

34.1.1 **For DHHS Licensed Facilities-Appendix C (Other than Adult Intellectual Disability Facilities):**

Principle. Payment of routine services costs will be made prospectively by the Department using audited 1998 costs (as filed or pro forma costs used in rate setting for new facilities) as a base year, inflated by the DRI index to July 1, 2001. The Department will set the routine services per diem for each facility at the lesser of the facility-specific inflated base year rate or the upper limit, whichever is less, and as of July 1, 2004, will reduce this amount by twenty-five cent (25¢) per diem. This becomes the facility-specific cap. Providers will be reimbursed for the average annual per diem cost for routine services up to the facility-specific cap. The average annual per diem cost for routine multiplied by bed days of care provided to members will determine reimbursement. Routine

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costs will be offset by the program allowance paid by the MaineCare program in accordance with Section 33.

Effective July 1, 2001, the Commissioner of DHHS has set the gross upper limit on routine costs per day at twenty-four dollars and ninety-five cents (\$24.95) for facilities with twenty-four (24) or fewer beds, twenty-eight dollars and fifteen cents (\$28.15) for facilities with twenty-five (25) or more beds, and thirty-two dollars and seventy cents (\$32.70) for specialty Alzheimer's facilities. This will be offset by the program allowance. For facilities that receive MaineCare payments for medical and remedial services under Section 97, Chapters II and III, Appendix C of the MBM, the Department may approve routine costs in excess of these amounts upon justification by the provider. In that event, the approved costs become the facility-specific caps, and the facility will not be subject to the upper limit contained in Section 34.1.1. In either event, as of July 1, 2004, the Department will reduce that amount by twenty-five cent (25¢) per diem.

34.1.2 For DHHS Licensed Facilities-Appendix F-Office of Aging and Disability Services

Effective July 1, 2001, DHHS Aging and Disability Services has set the upper limit on routine per diem costs at fourteen dollars and six cents (\$14.06). This is the net after the program allowance has been offset. Subsequent to that date, the upper limit will be adjusted annually to reflect the DRI index. For facilities funded by DHHS Aging and Disability Services, costs will be set prospectively using audited FY 1996 costs, removing medical supplies, inflated by the DRI index for FY 2001. Routine costs will be offset by the program allowance paid by the MaineCare Program in accordance with Section 33.

34.2 Bed-Hold Days

Providers may be reimbursed for up to thirty bedhold days per calendar year when the resident is absent from the facility. Billing codes are BL and MRBL.

34.3 Occupancy Adjustments

34.3.1 Principle. To the extent that per diem costs are allowable, such costs will be adjusted for providers with one (1) level of care whose annual level of occupancy is less than ninety percent (90%). The adjustment to the per diem costs shall be based on a theoretical level of occupancy of ninety percent (90%).

The above percentage level is eighty percent (80%) in those facilities licensed as Level III facilities.

34.3.1(a) For new providers whose first fiscal year of operation for audit reporting purposes will include nine months or less, the actual member census will be used, and the cap on routine services will be waived. For new providers coming into the system whose first fiscal

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year of operation for audit reporting purposes will include a period of time greater than nine (9) months, the ninety percent (90%) (and 80% in those facilities licensed as Level III facilities), occupancy adjustment will not apply for the first ninety (90) days of operation.

34.3.1(b) For all subsequent cost reporting periods after the reporting periods addressed in Section 34.3.1(a), the ninety percent (90%) and eighty percent (80%) occupancy requirements as stated in Section 34.3.1 will apply.

34.3.2 **Persons Living in Facilities Who Are Not Members.** In the event owners, employees, or others reside in the facility, all costs will be pro-rated over the total number of people residing there. Only those pro-rated costs related to serving members will be considered as allowable costs. Only the pro-rated share of utilities and food will be deducted in determining allowable costs in non-profit facilities, because the live-in staff has no ownership in the non-profit home. The following factors will be considered in determining if persons are residing in the facility: they generally treat the facility as if it were their home, they have no other permanent residence, they receive personal mail at the facility, they maintain their personal belongings at the facility, or they sleep in the facility, or they sleep in the facility for extended periods of time.

34.4 **Rates for New Facilities**

34.4.1 **Principle.** For facilities opened after July 1, 2001, the Department must approve a facility's initial routine and capital/fixed costs in order to receive payment under these Principles. A pro forma cost report and supporting documentation detailing the provider's total operating costs, including proposed direct care costs that will be covered by MaineCare, routine operating costs and capital/fixed costs, must be submitted in order to establish the initial interim rate. Required data includes ownership interests, related party interests, projected financial statements, sources and uses of funds, terms of any new or existing borrowing, detail of the total estimated/actual project costs such as for land, building/renovations/construction, equipment and soft costs, depreciation schedule, start up cost budget, and staffing schedule. This information will be provided on forms approved by the Department and must be of sufficient detail to substantiate costs projected on the pro forma cost report. The capital cost data will be reviewed by the Department and a calculation will be made of the maximum amount that the Department may reimburse for depreciation expense, interest expense, and start-up costs, thereby, establishing the provider's depreciable basis or historical cost. The interim rate for routine costs will be approved at the lesser of the pro forma cost report or the estimate average routine costs for the industry. Future routine cost caps will be established based on the audited costs for the first complete year of operation, subject to the upper limit.

34.4.2 The interim payment rate will be used to calculate over or underpayment to the provider after the provider submits a report of actual operating expenses and

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financial statements and the DHHS, Division of Audit, completes an audit of the provider's records.

- 34.4.3 Subsequent rates for the routine component will be calculated by taking the audited allowable routine costs (subject to the upper limit) for the first complete operating period and inflating them forward to the rate setting period. Capital/fixed costs will be based on actual allowable costs for the prior year and will not be inflated.

34.5 Final Settlements

- 34.5.1 After completion of the final audit, all overpayments or underpayments will be adjusted on a lump sum basis or as stated in Section 15. The final audit may consist of a full scope examination by the DHHS, Division of Audit personnel, and will be conducted on an annual basis.

Reimbursement will be limited to the total actual allowable fixed and routine service costs, not to exceed the facility-specific cap set for routine service costs per Section 34.1.1. These total allowable costs shall be divided by the actual number of bed days, or ninety percent (90%) of licensed capacity, whichever is greater (five (5) and six (6) bed facilities may use eighty percent (80%) of licensed capacity), in order to determine a cost per bed day.

The cost per bed day shall be multiplied by the number of MaineCare eligible days to determine the total reimbursable costs.

Final settlement consists of allowable costs determined through the audit, compared to the interim payments received by the provider.

34.6 Recovery of Overpayments

- 34.6.1 The Department will recover overpayments made to a provider either by set-off, recoupment, or any other method allowed by law.

- 34.6.2 The Department may withhold payment on pending or future claims in an amount equal to the overpayment. The amount may be withheld all at once or over a period of time established by the Department. Amounts are to be repaid within ninety (90) days of the date the audit is finalized unless otherwise negotiated with the Department.

- 34.6.3 Should there be insufficient claims sent to the Department against which the Department can set-off the amount of an overpayment, the provider shall be directed to remit payment in full. If repayment is not made, the Department may exercise any or all appropriate action against the provider and exercise all other civil remedies in order to recover the overpayments.

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34.7 **Appeal Procedure**

34.7.1 A facility may administratively appeal any of the following types of determinations through the DHHS, Division of Audit:

34.7.1(a) Audit adjustments and calculation of an audited per diem rate;

34.7.1(b) Adjustments to per diem rate;

34.7.1(c) Historical costs.

34.7.2 Administrative appeals will proceed in the following manner:

34.7.2(a) Within sixty (60) days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director, DHHS, Division of Audit or his/her designee. The facility must forward with the request, any and all specific information that is relative to the issues in dispute, note the monetary amount each issue represents, and identify the appropriate principle supporting the request. Only issues presented in this manner and time frame will be considered at an informal review or at subsequent administrative hearing.

34.7.2(b) The Director or his/her designee shall notify the provider in writing of the decision made as a result of such informal review. If the provider disagrees with the result of the informal review, the provider may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within sixty (60) days of receipt of the decision made as a result of the informal review. The hearing shall proceed in accordance with the Department's Administrative Hearings Manual.

34.7.2(c) To the extent the Department rules in favor of the facility, the audit report will be corrected.

34.7.2(d) To the extent the Department upholds the original determination of the DHHS, Division of Audit, that decision may be appealed pursuant to the Administrative Procedures Act, 5 M.R.S.A. §11001 *et seq.*

34.7.3 **Informal Review Prior Approvals**

A. **For - Appendix C Medical and Remedial Service Facilities:**

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If DHHS denies a request in whole or in part for approval of any item requiring prior approval, the provider may request an informal review of the decision from the Division of Licensing and Certification . A request for informal review must be made to the Director, Office of MaineCare Services, 11 State House Station, Augusta, Maine 04333-0011, within thirty (30) days of the denial. Any further appeal will proceed according to Section 34.7.2(b) of these Principles.

B. For Appendix F Non-Case Mixed Medical and Remedial Services Facilities

If DHHS Office of Aging and Disability Services denies a request in whole or in part for approval of any item requiring prior approval, the provider may request an informal review of the decision. A request for informal review must be made to DHHS Office of Aging and Disability Services, Program Director, Intellectual Disability Services, 11 State House Station, Augusta, Maine 04333-0011 within thirty (30) days of the denial. The request for review shall state the reasons for the request and shall be accompanied by any supporting documentation. The program director shall forward a written response to the provider within thirty (30) days of receipt of a complete request for review. If the decision of the program director is denied, any further appeal shall follow 14-191 CMR Chapter 40, of the service agreement.

34.8 Deficiency Per Diem Rate

34.8.1 When certain conditions relating to these Principles are found in a facility receiving payment under these Principles, the Department may reduce reimbursement to ninety percent (90%) of the provider's per diem rate. This "deficiency rate" will be applied thirty (30) days following the provider's receipt of written notice of the specific condition that exists. If the provider can present documentation prior to the effective date of the "deficiency rate" that the condition no longer exists, the "deficiency rate" will not be applied. If the condition is not corrected, a reduction in rate will remain in effect until the records are corrected and verified by the DHHS, Division of Audit. Written notification of whether the Department believes the deficiencies have been corrected will be sent to the provider. No retroactive adjustments to the full rate shall be made for the period that the "deficiency rate" is in effect if it is properly invoked.

Conditions under which a ninety percent (90%) "deficiency rate" will be invoked include:

34.8.1(a) Failure to submit a cost report and financial statement within five (5) months of the end of the provider's fiscal period.

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34.8.1(b) Failure to produce accurate and auditable financial and statistical records in sufficient detail to substantiate at least ninety-eight percent (98%) of total costs reported by the provider. Required records are described in Section 18.

34.8.2 If the provider can produce verifiable records to document at least ninety-eight percent (98%) of its reported expenses, then the undocumented expenses will be disallowed but no “deficiency rate” will be applied.

34.8.3 When a “deficiency rate” has been in effect for three (3) months and the deficient condition has not been corrected, the provider may be notified of the suspension of the Provider Agreement and/or Service Agreement. This will be effective one month from receipt of notice. The Department will not reimburse the provider for any services provided after the effective date of the suspension of the Provider Agreement/Service Agreement. The provider shall submit a final cost report in the case of termination of the Provider Agreement/Service Agreement in accordance with the cost reporting requirements.

34.9 **Inflation Adjustment**

The Commissioner of the Department will determine if an inflation adjustment will be made and the amount of that adjustment.

For the state fiscal year ending June 30, 2020 and each year thereafter, the MaineCare payment rates attributable to wages and salaries in routine services costs for Appendix C PNMI's must be increased by an inflation factor in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index – medical care services index from the prior December for professional services, nursing home and adult day care services.

35 **CIVIL MONETARY PENALTIES**

In the event the Department issues civil monetary penalties against a provider, in accordance with 22 M.R.S.A. §7941 et. seq., the Department may collect these amounts in accordance with the same procedures for recovering overpayments, as described in Section 34.6.

36 **TERMINATION UNDER TITLE XIX**

Termination of participation in the MaineCare Program shall result in the provider being terminated simultaneously from financial participation in room and board payments under these Principles.

37 **DAYS WAITING PLACEMENT**

37.1 For current nursing facility residents who have no federal third party coverage or long term care insurance coverage and who have been determined not medically eligible for MaineCare nursing facility benefits, the nursing facility in which that member resides

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37 **DAYS WAITING PLACEMENT** (cont.)

may receive payment at the “Days Waiting Placement” rate retroactive to the date the nursing facility ceased receiving other payment for the member, subject to the following conditions:

- 37.1.1 The resident has received notice that they are not medically eligible for MaineCare benefits, the facility has initiated the discharge process, and it has been determined that there is no safe and appropriate placement currently available.
- 37.1.2 The individual meets the financial eligibility requirements for MaineCare coverage in a cost reimbursed residential care facility, as determined by the regional Office of Family Independence.
- 37.1.3 The member met the MaineCare medical eligibility criteria in effect at the time of admission to the nursing facility. The nursing facility shall conduct an assessment using the Department’s approved medical eligibility determination assessment form (MED) to document the member’s medical eligibility. Only if the member was admitted prior to the MED assessment, a completed MDS may be substituted for the MED.
- 37.1.4 The nursing facility accepts as payment in full the rate of reimbursement for days awaiting placement and does not receive any additional payment from a third party to supplement this rate.
- 37.1.5 The nursing facility continually pursues discharge of the member. The nursing facility shall continue to document in the member’s record all efforts to locate appropriate placement.
- 37.1.6 The member accepts the first available, appropriate placement within a thirty (30) mile radius of his/her residence (Chapter II, Section 67, Nursing Facilities, Definitions of the MBM). The member may accept a placement beyond the thirty (30) mile radius. However, this is not required. The nursing facility must notify the Department if a member refuses a placement meeting these criteria. If the member refuses this placement, the Department will issue a thirty (30) day notice to the nursing facility that reimbursement will terminate.
- 37.1.7 The Department will reimburse the difference between the eligible member’s assessment (cost of care) and the rate determined by the Department. This rate shall be published on July 1st of each year and shall be equal to the sum of the Statewide average cost reimbursed residential room and board rate less fixed costs and the administrative allowance, and the average MaineCare rates. It is the responsibility of the nursing facility to assist the member in applying for any benefits that the resident may be eligible for, such as federal Supplemental Security Income, that might be applied toward the member’s cost of care. Payments will not be considered in the reconciliation of the nursing facility’s cost report. This includes removal of the days of care from the nursing home census in such reconciliation.

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38 **Hearings**

- 38.1 Appeals to decisions made under Section 37 shall be made to the Administrative Hearings Unit of the Department of Health and Human Services. The request must be made in writing within thirty (30) days of the initial denial, to the:

Office of Administrative Hearings
Department of Health and Human Services,
11 State House Station
Augusta, Maine 04333-0011

Hearings will be held on an expedited basis and a written decision will be rendered within thirty (30) days of receipt of the request. The Office of Administrative Hearings will arrange the date, time, and place of the hearing, and shall designate a presiding officer. The individual requesting the hearing will be given at least twenty (20) days advance notice of the hearing date. The hearing shall be held in conformity with the Maine Administrative Procedures Act, 5 MRSA §8001 et seq. and the Department's Administrative Hearings Manual. The presiding officer shall issue a written decision and findings of fact or, pursuant to provisions of the Administrative Hearings Manual, issue a written recommendation to the Commissioner of the Department of Health and Human Services who will make the final decision.

- 38.2 When a medical assessment by a medical authority other than the one involved in the decision under question is requested by the hearings officer or the member and considered necessary by the hearings officer, it will be obtained at the Department's expense and forwarded to all parties involved, allowing all parties to comment.
- 38-.3 The decision(s), rendered by the hearing authority, in the name of DHHS, will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reversing final decision-making authority to him or herself.

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