Sec. 17-311-52. Computation of per diem reimbursement rates

Per diem reimbursement rates shall be calculated for each level of care, e.g., chronic and convalescent hospital, rest home with nursing supervision and home for the aged, based upon:

(a) Allowable routine costs related to the provision of patient care as set forth in subchapter 18, part A of title 42 of the U.S. Code, section 1393 et seq. and the regulations promulgated thereunder (hereinafter referred to as medicare statutes and regulations) except as modified by these regulations and the Connecticut state plan approved by the United States department of health and human services.

(b) The allowable salary limits pursuant to the following schedule:

(1) For 1986

Administrators'

Number of Beds Within Level of Care	*Base*	*Add per Bed Increment*	*Maximum*
Homes for the Aged and Other Community Group Homes			
1-60	$20,000	92	$25,530
61-120	25,530	101	31,590
121-over	31,590	80	36,465
Rest Home with Nursing Supervision			
1-30	$20,000	108	$23,253
31-60	23,253	236	30,333
61-120	30,333	110	36,933
112-180	36,933	112	43,653
181-over	43,653	110	50,254
Chronic and Convalescent Hospital and Multi-level Facilities			
1-60	$21,537	$238	$35,817
61-120	35,817	176	46,379
121-180	46,379	133	54,359
181-over	54,359	112	61,078

Assistant Administrators

For facilities of over 99 certified beds, one assistant administrator (in addition to the administrator) may be allowed for each 100 beds at a salary of up to a maximum of 70% of the allowable salary paid to the administrator.

Director of Nurses

Number of Beds	*Base*	*Add per Bed Increment*	*Maximum*
1-60	$15,042	$166	$25,002

61-120	25,002	125	32,502
121-180	32,502	93	38,082
181-over	38,082	77	42,733

Dietitions

Number of Beds	*Code Requirements*	*Rate of Pay*
60 and under	8 hours per month	B.S. Degree only $17.78 per hour B.S. Degree and ADA and RD $19.71–23.71 per hour
61-90	16 hours per month	As Above
91-120	24 hours per month	As Above
121-150	32 hours per month	As Above
151-180	48 hours per month	As Above
181-210	64 hours per month	As Above
211 or more	Full Time Dietitian	As Above

Physicians

$56.52 – $80.91 per hour

All other Professional/Technical Personnel Related to the Owner(s)

Salary for full-time work $17,633

(2) The allowable salary limits for ensuing years shall be determined by applying the percentage increase or decrease of the forecasted implicit price deflator for the gross national product for the appropriate period to the allowable salary limits for the preceding cost year, except that commencing with the rate year beginning July 1, 1983 salaries for directors of nursing unrelated to the owner(s) shall no longer be subject to such limitations and commencing with the rate year beginning July 1, 1986 salaries for other professional/technical personnel unrelated to the owner(s) shall no longer be subject to such limitations but rather must meet the general standard of being reasonable, necessary and directly related to patient care.

(3) Salaries for proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who claim to provide some or all of the functions required to operate the facility efficiently shall be supported by timekeeping records and other related documentation. For a proprietor or relative licensed by the Connecticut Department of Health Services as the administrator, compensation shall be allowed in accordance with the allowable administrative salary limits referred in the preceding paragraph. For proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who are not so licensed, allowable compensation for managerial administrative functions shall be limited to 70% of the allowable salary paid to the administrator. The

salary allowed for a proprietor or relative shall not exceed the allowable salary limits based on a 40 hour work week.

(c) A separate inflation cost limitation for each of the following cost centers; dietary, laundry, housekeeping and routine nursing care; excluding routine nursing care for non-medical facilities such as homes for the aged.

Each inflation cost limitation shall be the sum of;

(1) Allowable costs per patient day for the prior year for the cost center without consideration of the prior year inflation control disallowance or cost efficiency adjustment, adjusted by the implicit price deflator for the gross national product published in "Economic Indicators" prepared for the joint economic committee by the council of economic advisors for the current cost year divided by the implicit price deflator for the gross national product for the prior cost year.

(2) The portion of real wage growth allowance per patient day for the prior year applicable to the cost center computed in accordance with subsection 16 below.

(3) Significant increases in operating costs of the cost center resulting from the implementation of new standards of care of staff specifically mandated by the Connecticut Department of Health Services and/or the certification requirements of the federal government.

(4) Significant increases in operating costs of the cost center resulting from capital renovation, expansion or replacement required for compliance with new state or federal standards for patient care referred to in (c) above.

(d) An efficiency limitation per patient day established at 160 percent of the median for all allowable costs except those property costs covered by the application of the fair rental value system. The efficiency limitation shall be determined by calculating such costs per patient day for each provider segregated by chronic and convalescent hospitals and homes for the aged. This efficiency limitation shall be cost controlling after application of subsection 3 above and any other disallowances prescribed by these regulations. This efficiency limitation shall decrease by five percentage points per year for each of the next two years. This efficiency limitation shall remain at 150 percent of the median thereafter.

In no event shall the efficiency limitations per patient day computed pursuant to this subsection be less than the allowable operating expense per patient day for the preceding cost year.

This subsection constitutes an overall cap which a facility's allowable costs for reimbursement purposes cannot exceed. All other subsections of the cost related reimbursement system regulations, including but not limited to Section 17-311-57, shall be construed to be subject to this subsection.

(e) For chronic and convalescent hospitals and rest homes with nursing supervision excluding intermediate care facilities for the mentally retarded, a separate cost efficiency adjustment for each of the four cost centers; dietary, laundry, housekeeping and routine nursing care; and for homes for the aged, a separate cost efficiency adjustment for each of the three cost centers; dietary, laundry and housekeeping.

For chronic and convalescent hospital and rest home with nursing supervision excluding intermediate care facilities for the mentally retarded, for the dietary, laundry and housekeeping cost centers, the cost efficiency adjustments shall be 10% of the excess of

the 80th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care, provided such excess exists for at least two cost centers for the applicable level of care and provided such excess is at least $1,000 for the applicable cost center. For chronic and convalescent hospitals and rest home with nursing supervision, excluding intermediate care facilities for the mentally retarded, for routine nursing cost center, the cost efficiency adjustment shall be 10% of the excess of the 90th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care over the allowable expense of the facility for the cost center, provided such excess exists for at least two cost centers for the applicable level of care and provided such excess is at least $1,000 for the routine nursing cost center.

For homes for the aged, for dietary, laundry and housekeeping cost centers, the cost efficiency adjustment shall be 10% of the excess of the 80th percentile of allowable costs per certified bed of all homes for the aged for the cost center multiplied by the certified beds of the facilities' home for the aged over the allowable expense of the facilities' home for the aged for the cost center, provided such excess is at least $1,000 for the applicable cost center.

After a facility has received a cost efficiency adjustment for a cost center of a level of care for two years in a row, that is, beginning with the third year, the cost efficiency adjustment shall be increased to 20% of the excess described above.

(f) **An allowance for property costs based upon a fair rental value system.**

(1) The fair rental value allowance shall be in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-movable equipment and rental charges (except for leases entered into between unrelated parties prior to December 20, 1976). The allowance shall be computed in the same manner whether the facility is owned or leased (except as provided in subsection c) and whether the facility is operated by an individual owner, partners, or a corporation.

(2) The fair rental value allowance consists of rental allowance of the use of land, buildings and non-movable equipment related to patient care.

(a) The annual fair rental value allowance for the use of land shall be determined by multiplying the base value of the land by a rate of return which is equal to one-third of the medicare rate of return for the cost year, but not more than four percent nor less than two and one-half percent per annum. The base value of the land of a facility first used as a long term care facility after September 30, 1954, shall be the actual cost of the land consisting of the purchase price and the cost of grading, filling and site preparation. For those facilities first used as a long term care facility before October 1, 1954, the base value of the land shall be the actual cost of the land adjusted from the date of acquisition to cost year 1974. The base value in any case shall not vary because of changes in ownership except as provided in section 17-311-57(1), financial arrangements of an owner, or whether the land is owned or leased.

(b) Real property other than land consists of:

- buildings and building improvements;
- all equipment attached to buildings and considered to be real property as distinguished from personal property; and

• land improvements, including parking lots, driveways, sidewalks, sewage systems, walls and pump houses.

The fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs, such allowance for the use of real property other than land shall be determined by amortizing the base value of such property over its remaining useful life and applying a rate of return on the unamortized base value.

The annual rate of return shall be calculated for proprietary facilities on the basis of medicare rates of return as set forth in 42 C.F.R., Section 405.429, and 5/8th of such rates for nonprofit (voluntary and governmental) facilities. The applicable rate of return shall remain constant for each property item for a period of ten years. Thereafter each subsequent ten years, the rate of return shall be adjusted based upon the preceding five year average of the medicare rate of return.

For proprietary facilities, the applicable rate of return for real property other than land, first used for a long term care facility after September 30, 1974 or acquired by new owners between October 1, 1974 and December 20, 1976, shall be the medicare rate of return for the cost year when first used for a long term care facility or acquired by new owners, respectively. The applicable rate of return for all other real property other than land shall be based on the cost year that such property was first used for a long term care facility as follows:

• Cost Year 1974 — 1974 medicare rate of return;
• Cost Year 1973 — average of 1973 and 1974 medicare rates of return;
• Cost Year 1972 — average of 1972, 1973 and 1974 medicare rates of return;
• Cost Year 1971 — average of 1971, 1972, 1973 and 1974 medicare rates of return;
• Cost Years Prior to 1971 — average of 1970, 1971, 1972, 1973, and 1974 medicare rates of return.

For nonprofit (voluntary and governmental) facilities, constructed or acquired after the effective date of this amendment to the regulations, the applicable rate of return utilized in calculating the fair rental value shall be the same rate of return as that used for proprietary facilities.

The base value of real property other than land first used for a long term care facility after September 30, 1974 and December 20, 1976, shall be the actual cost of the property. The base value of all other real property other than land shall be the undepreciated book value of the property as of October 1, 1974; that is, the cost less the accumulated depreciation, from the date of acquisition, allowable under medicare statutes and regulations.

In any situation where book values are incomplete or questionable and therefore may not reflect the value on the date of acquisition, the commissioner may disallow any claim for such unsupported amount or may in his discretion establish a value based on property values of comparable facilities.

A facility transferred to a new owner after December 20, 1976 retains the same base values as existed for the previous owner except as provided in section 17-311-57 (1).

The remaining useful life of buildings first used as a long term care facility after September 30, 1974, or acquired by new owners between October 1, 1974 and December 20, 1976, shall be thirty years. The remaining useful life of all other buildings except those acquired by new owners after December 20, 1976 shall be thirty years minus the number

of years between October 1, 1974 and the date of building construction, reconstruction sufficient to extend its useful life to thirty years, or acquisition, whichever is later. The remaining useful life of buildings acquired by new owners after December 20, 1976 shall be the same as if the buildings had not changed ownership after December 20, 1976, except as provided in section 17-311-57 (1).

The remaining useful life of real property other than buildings shall be determined as described herein for buildings with the exception that for such property whose estimated useful life is less than thirty years, such estimated useful life shall be used in all calculations instead of thirty years.

For purposes of reimbursement, a minimum residual value is established for real property other than land at 10% of the cost of such property. The allowance for the use of such property shall not be less than the amount determined by applying the appropriate medicare rate of return to the minimum residual value.

(3) A facility which has entered into a lease with an unrelated party prior to December 20, 1976 may petition the state to recognize the arms-length relationship of the parties and the process and procedure leading to the terms and conditions of an existing lease when the terms and conditions were arrived at through arms-length negotiations with unrelated parties. Any provider who is such a lessee must provide full detailed information, including copies of such leases and proof of arms-length relationship. In addition, a formal written letter requesting the recognition of such an arrangement must be included in the annual report transmitted to the commissioner each year for which such consideration is desired.

Upon acceptance of satisfactory proof of an arms-length relationship and upon review of the terms of said lease for reasonableness, the commissioner may accept the continuation of the rental or lease agreement and may decide not to impose the rules and regulations applicable under the fair rental value system until the lease expires.

(g) **Management service fees.**

Management fees paid to related parties shall be recognized only to the extent of the actual cost to the related party of providing necessary services related to patient care.

Fees paid to outside organizations for management services shall be allowed for inclusion in the computation of the per diem reimbursement rate provided that such costs are paid under arms-length arrangements to unrelated parties and are approved by the commissioner.

Requests for approval shall be submitted annually by the provider to the commissioner at least three months in advance of entering into arrangements for outside management services. Such requests shall be reviewed as to their reasonableness in relation to the size of the facility and the complexity of its operating structure, and as to their necessity for the effective administration of the facility's operations. The granting of approval will provide the basis for recognition of the costs of the requested management services in the cost year in which they are incurred and inclusion in the rate to be effective July 1 of the following year.

(h) Allowances for membership in professional associations whose function is to improve the competence of administrators and professional staff serving patients up to a maximum of $24.00 per bed for the cost year ending September 30, 1986. For the cost years ending September 30, 1987, September 30, 1988, and September 30, 1989, increases in such dues paid by providers to professional associations in excess of $24.00 per bed will

be recognized as an allowable cost to the extent that such percentage increase in such association dues does not exceed the percentage increase in the implicit price deflator for the gross national product (GNP) as determined in subsection (c) (1) of this regulation. As a condition precedent for professional dues to be recognized as allowable costs, the professional association must file with the department not later than March 31 of each year an annual report for the fiscal year ending December 31 of the prior year setting forth all revenues received and all expenses incurred during such fiscal year.

(i) **Exclusion of unallowable costs.**

All costs included in the computation of the per diem reimbursement rate must be reasonable and directly related to the provision of services necessary for patient care. In addition to those costs specifically disallowed pursuant to the medicare statutes and regulations as modified by these regulations, items to be excluded from the calculation of the rate shall include but not be limited to:

(1) duplications of functions or services.

(2) expenditures made for the protection, enhancement, or promotion of a provider's interests.

(3) educational expenditures to colleges or universities for tuition and related costs for owners or employees.

(4) directors' fees.

(5) expenditures made for the personal comfort, convenience or transportation of owners or employees.

(6) travel for purposes of attending conferences or seminars outside of the continental United States. Other out-of-state travel to attend bona fide professional seminars must be limited to no more than one representative from the participating facility and the total dollars expended must meet the medicare definition of reasonableness.

(7) outpatient services, day care services and meals-on-wheels.

(8) costs of residences which are not certified as long term care facilities.

(9) bad debts.

(10) advertising except for help wanted ads.

(11) Expenditures made for salaries, fringe benefits or any type of reimbursement to or for any person who is convicted in any state or federal court of a crime involving fraud in the medicare program or medicaid program or aid to families with dependent children program or state supplement to the federal supplemental security income program or any federal or state energy assistance program or general assistance program and is under a resultant termination or suspension from participation in any of said programs. If such termination or suspension results from a conviction pursuant to Connecticut General Statutes Section 17-83k, such termination or suspension shall be effective with the date of conviction notwithstanding the plea entered prior to conviction.

Costs to be excluded from per diem reimbursement rate determination pursuant to the above should be specifically identified in the appropriate section of the annual report.

(j) Exclusion of costs of legal, accounting and consultant services, and related costs incurred in connection with rehearings, arbitration or judicial proceedings pertaining to the reimbursement rates approved by the commissioner, except that such costs shall be recognized as allowable if the commissioner, the arbitration panel or the court concludes

that the facility's request for reimbursement rate adjustment constitutes a valid claim. In such situations, the reasonable aggregate amount of legal, accounting and consultant services, and related costs to be allowed shall be determined by the commissioner.

(k) **Disallowance of interest expense except as noted below.**

For proprietary facilities, all interest expense on any form of indebtedness shall not be allowed as reimbursable expense, since proprietary facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment and a return on equity pursuant to subsection 12 below for the use of all other assets related to the provision of current patient care.

For non-profit facilities, only interest expense required to obtain necessary working capital shall be allowed as a reimbursable expense, all other interest expense shall be disallowed, since non-profit facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment.

The disallowance of interest expense described in the two preceding paragraphs does not preclude capitalization of interest during the period of construction of a new facility or an addition to an existing facility and the inclusion of such capitalized interest in the cost of construction.

(*l*) **Return on equity.**

Proprietary facilities shall be allowed a return on equity which is determined by multiplying the medicare rate of return for the cost year by the average current equity for the cost year and the average non-current equity for the cost year. For facilities which submit an annual report for less than a full year of operation, the return on equity will be adjusted in proportion to the length of the annual report period.

Current equity shall be equal to current assets which are related to current patient care minus current liabilities which are not interest bearing and are not owed to owners or related parties.

Non-current equity shall be equal to non-current assets which are related to current patient care and are not subject to the fair rental value system minus non-current liabilities which are not interest bearing and are not owed to owners or related parties. For some facilities, non-current equity consists of only movable equipment net of depreciation, because other non-current assets are either unrelated to patient care or subject to the fair rental value system, and all non-current liabilities are either interest bearing or are owed to owners or related parties.

For purposes of this section, equity shall not include assets which are not related to current patient care, such as, but not limited to, investments, loans to owners or related parties, marketable securities, cash in excess of average monthly operating requirements (computed by dividing twelve into the annual operating costs related to patient care exclusive of inflation and efficiency adjustments and non-cash items such as, but not limited to, depreciation and amortization), construction-in-progress and monies available for the completion of construction, real property held for future use and goodwill which was not purchased or which was purchased after December 20, 1976. Also, equity shall not include assets which are subject to the fair rental value system, such as, but not limited to, land, buildings, and non-movable equipment since facilities are allowed a fair rental value allowance for the use of such assets.

Since interest is not a reimbursable expense, equity is not reduced by interest-bearing liabilities so that facilities may receive a return on such indebtedness. Also, equity is not reduced by loans from owners or related parties so that facilities receive a return on such indebtedness. The basis for calculating return on equity does not vary whether the facility is fully funded by owners' capital or funded in whole or in part by debt.

All inclusions in, and exclusions from, equity cited in the medicare statutes and regulations which are not discussed above shall be recognized and given full effect in the calculation of equity.

As a minimum, a proprietary facility shall be allowed a return on equity in an amount sufficient to meet the cost of borrowing for working capital needs provided that the working capital loan is one which:

(1) has a due date no greater than 12 months.

(2) is payable to a bank or recognized finance company which makes such loans to the general public and is an unrelated entity, and

(3) is necessary and proper for the current operation and maintenance of the facility as measured by average monthly cash requirements, and is not used for acquisition of fixed assets or for unallowable and non-patient related expenditures.

(m) **A limitation of the total allowable costs for each level of care of nonprofit long term care facilities.**

For non-profit facilities, the aggregate total allowable costs shall not exceed the costs submitted by the provider plus efficiency adjustments, less unallowable costs exclusive of those not required under applicable federal regulations, e.g., inflation and efficiency limitations, salary controls, and the effect of the fair rental value system.

(n) **Computation of per diem reimbursement rates for each level of care.** For rate determination purposes, no sub-classifications within levels of care shall be allowed.

(o) **The total costs as adjusted by the procedures referred to above divided by the minimum allowable patient days for the applicable cost year.**

A patient day is the unit of measurement for lodging provided and services rendered to one inpatient between the census-taking hour on two successive days. In computing patient days, the day of admission shall be counted but the day of discharge shall not. In computing patient days, reserve bed days shall be counted.

For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of 90% of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

(p) **An adjustment in the rate for the time lag between the cost period and the rate period.**

This adjustment shall be the gross national product (GNP) deflator percentage increase or decrease for the eighteen-month time lag from the cost year ending September 30 to the twelve months ending March 31 of the succeeding rate year. This factor shall be computed annually on or about April 15 preceding computation of annual rates to be effective the following July 1. Because the GNP deflator used in the initial rate calculation is estimated in part, when official quarterly rates are finalized, the rate shall be adjusted, if the absolute difference is more than 5% of the factor and commencing with the July 1, 1984 to June 30,

1985 rate year, if the absolute difference is more than 3 percentage points, with the final adjustment to be made based upon the data available on December 31 following the close of the rate year.

(q) **An allowance for real wage growth.**

Such allowance shall be predicated upon a factor determined by using a ten-year moving average of the changes in non-manufacturing real wages in Connecticut reported by Chase Econometric Associates, Inc. The ten-year moving average shall extend through the end of the calendar year covered by the annual report used for the determination of the per diem reimbursement rate. The real wage growth allowance is limited to wages paid excluding fringe benefits and applies only to employees paid on an hourly rate basis (excluding salaried employees). Reasonable costs mandated by collective bargaining agreements between the employer and other agreements between the employer and the employees shall be allowed to the extent that such costs are reasonable.

(r) **Separate reimbursement for minimum wage increases.**

Beginning with the effective date of any legislative action which increases the minimum wage rate for labor, the commissioner shall pay long term care facilities the portion of the resulting increase in wage costs for employees thus affected applicable to medicaid patients and supplemental security income recipients. For this purpose, each provider may submit cost data identifying the wage increase on a quarterly basis in the manner prescribed on such forms provided by the department.

(s) **Specified limitations on per diem rates.**

(1) per diem rates for facilities caring for recipients under the medicaid program and/or the supplemental security income program shall not exceed the rate of payment for self-pay persons, or the general ceiling for payment for medicare.

(2) per diem rates for homes for the aged and community residences for the mentally retarded shall not be less than the rate determined pursuant to section 17-311-54.

(t) **Related party principle 42 C.F.R. Sec. 405.427 is incorporated by reference as a minimum standard and hereby made a part of this regulation.**

(u) **Adjustment of rates to provide payment for increased reasonable costs or expenditures necessitated by changes in law.**

(1) If changes in federal or state laws, regulations or standards related to the provision of patient care adopted subsequent to June 30, 1985, results in increased costs or expenditures, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this subsection shall be construed to require the department of income maintenance to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the department of health services.

(2) Any facility which believes itself qualified for rate adjustment pursuant to subsection (1) above must petition the department of income maintenance on forms to be prescribed by the Department specifying the change in federal or state law, regulation or standard adopted subsequent to June 30, 1985, the exact amount of the increased reasonable cost or expenditure incurred to comply with such change in law, and the exact identity of the added staffing, goods or services utilized to come into compliance.

(v) **Nursing Pool Costs.**

(1) For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the wages of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such wages shall be further divided so that seventy-five percent of the excess cost shall be considered an administrative or general cost and twenty-five percent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost years are equal to or exceed fifteen percent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen percent shall be classified as administrative or general costs.

(2) Any facility which believes subsection (1) above to be applicable to it must complete the pertinent section of the annual report prescribed by the Department. Failure to complete said section shall result in all nursing expenditures being classified as nursing costs.

(w) **Providers concerning which payment checks are issued directly to patients or residents.**

Concerning all providers whose patients or residents receive payment checks directly from the department (i.e., the beneficiary-resident receives the payment check rather than the provider-vendor), the department is authorized to include as a factor in setting an annual rate any past unallowable costs which resulted in past overpayments so as to recover such past overpayments.

(Effective June 2, 1986)