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TITLE 460 DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES

LSA Document #00-63(F)

DIGEST

Amends 460 IAC 1-3 to remove references to the "Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily rate" since this rate is no longer publicly accessible and replace it with another rate that has been historically similar to the Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily rate, and to make other changes to rule provisions to remove unnecessary language, make the provisions consistent with other existing rules and statutes, and clarify current procedures. Effective 30 days after filing with the secretary of state.

460 IAC 1-3-1
460 IAC 1-3-4
460 IAC 1-3-5
460 IAC 1-3-8
460 IAC 1-3-9
460 IAC 1-3-10
460 IAC 1-3-13
460 IAC 1-3-14
460 IAC 1-3-15

SECTION 1. 460 IAC 1-3-1 IS AMENDED TO READ AS FOLLOWS:

Rule 3. Rate-Setting Criteria for Providers in the Assistance to Residents in County Homes Program (ARCH) and the Room and Board Assistance Program (RBA)

460 IAC 1-3-1 Policy; scope
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for the reimbursement of providers of residential maintenance services in Indiana's assistance to residents in county homes program (ARCH) and the room and board assistance program (RBA). All payments referred to within this rule for the ARCH or RBA provider are contingent upon the provider's

~~(1) proper and current certification standards of the state of Indiana; and~~

~~(2)~~ compliance with all applicable statutes and rules.

(b) The procedures described in this rule set forth methods of reimbursement to promote quality residential maintenance, efficiency, economy, and consistency. This reimbursement methodology is predicated on a reasonable, cost related basis which is designed to meet the cost, determined by generally accepted accounting principles, that must be incurred by efficiently and economically operated facilities.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a claim from the division, the provider must complete the appropriate billing adjustment form and reimburse the division for the amount of the overpayment with any interest which may be due in accordance with subsection (e).

(d) The division may implement rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the division to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the division, providing the provider avails itself of the opportunity to make such an appeal.

(e) If a provider fails to reimburse the division for the amount of an overpayment or fails to enter into agreement for the repayment of an overpayment within thirty (30) days of receipt of a notification demanding repayment, the division shall assess an interest charge in addition to the overpayment demanded. The interest charge shall not exceed the percentage set out in IC 24-4.6-1-101. The interest charge shall be applied to the amount of the overpayment, beginning with the date of the overpayment. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-1; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2196; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1344)*

SECTION 2. 460 IAC 1-3-4 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-4 Financial report to division; annual schedule; prescribed form; extensions; penalty for untimely filing
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 4. (a) Each provider shall submit an annual financial report to the division not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial acceptance of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the division. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following, as a minimum:
(1) Resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Certification by the provider that the data is true, accurate, related to resident maintenance, and that expenses not related to resident maintenance have been clearly identified.
(8) Certification by the preparer, if different from the provider, that the data was compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the division circumstances that preclude a timely filing. Requests for extensions shall be submitted to the division, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The division shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the division.

(d) Failure to submit an annual financial report in the time limit required shall result in the following actions:
(1) No rate review requests shall be accepted or acted upon by the division until the delinquent report is received.
(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the division. **No rate adjustments will be allowed until the first day of the first month after the delinquent annual financial report is received by the division.** Reimbursement lost because of the penalty cannot be recovered by the provider.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-4; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2200; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1345)

SECTION 3. 460 IAC 1-3-5 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-5 New provider; initial financial report to division; criteria for establishing initial interim rates; supplemental report; base rate setting
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation ~~or a new type of certified service,~~ or for a change of provider status shall be filed by completing the budget financial report form and submitting it to the division on or before thirty (30) days after notification of the ~~certification date or establishment of a new service.~~ **date of approval to participate.** The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests as set out in this rule. Initial interim rates shall be effective upon provider approval to participate. ~~or the date that a service is established, whichever is later.~~

(b) The methodology, set out in this rule, used to compute rates for active providers shall be followed to compute initial interim rates for new providers, except that historical data is not available, and the maximum allowable annual rate increase limitation shall not apply.

(c) Since an initial interim rate is established based upon forecasted financial data only, the provider shall file a nine (9) month financial report within sixty (60) days following the end of the first nine (9) months of operation, together with forecasted data for twelve (12) months of operation. This twelve (12) month period of forecasted data shall start on the first day of the tenth month ~~of certified operation~~ **from the date** of **approval to participate for** the facility. The nine (9) months of historical financial data and the twelve (12) months of forecasted data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month ~~of certified operation~~ **from the date of approval to participate** until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of acceptance falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of enrollment falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month ~~of certified operation.~~ **with approval to participate.**

(d) The base rate may be in effect for longer or shorter than twelve (12) months of forecasted data. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

(e) The base rate established from the nine (9) months of historical data and the twelve (12) months of forecasted data shall be the rate used for determining subsequent limitations on annual adjustments.

(f) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the division circumstances that preclude a timely filing. Request for extension shall be submitted to the division, prior to the date due, with full and complete explanation of the reason an extension is necessary. The division shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the division.

(g) In the event the provider fails to submit nine (9) months of historical financial data and the twelve (12) months of forecasted data as required in subsection (c), the following action shall be taken:

(1) When submission of the nine (9) months of historical financial data and the twelve (12) months of forecasted data is thirty (30) days past due and an extension has not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after acceptance and shall so remain until the first day of the month after receipt of the report by the division. **No rate adjustments will be allowed until the first day of the first month after the delinquent reports are received by the division.**

(2) Reimbursement lost because of the penalty cannot be recovered by the provider.

(h) Neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as defined in this rule.

(i) The change of provider status shall be rescinded if subsequent transactions cause a capitalized lease to be reclassified as an operating lease under the guidelines established by the American Institute of Certified Public Accountants. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-5; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2200; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1346)*

SECTION 4. 460 IAC 1-3-8 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-8 Limitations or qualifications to ARCH/RBA reimbursement; advertising; vehicle basis; litigation expenses
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with ~~facility certification~~ **statutory and regulatory** requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) resident care related automobile to be included in the vehicle basis for purposes of cost reimbursement under this rule. "Vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

(c) Except as provided in subsections (d) and (e), legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the division as reasonably related resident expenses under the program if the expenses are incurred in an administrative or judicial proceeding against any agency of the state or the federal government.

(d) Providers may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met:
(1) The costs have actually been incurred and paid.
(2) The costs are reasonable expenditures for the services obtained.
(3) The provider has made a good faith effort to settle all disputed issues before the completion of the administrative or judicial proceeding.
(4) The provider prevails on all issues that were in dispute.

(e) If a cost based provider satisfies the conditions of subsection (d), the provider may report the costs for potential cost recognition in the fiscal period when a final determination in the administrative or judicial proceeding is made. Costs reported under this section are subject to the same limiters used to determine allowable costs and to set rates as all other areas of reporting. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-8; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2203; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1346)*

SECTION 5. 460 IAC 1-3-9 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-9 Criteria limiting rate adjustment granted by division
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 12-15-14; IC 16-28-2; IC 24-4.6-1-101; P.L.24-1997, SEC.68

Sec. 9. ~~(a)~~ The reimbursement system for facilities licensed under IC 16-28-2 is based on recognition of the provider's allowable costs, plus a potential profit add-on payment. The reimbursement system for facilities that are not licensed under IC 16-28-2 is based on recognition of the provider's allowable costs. The payment rate is subject to several limitations. Rates will be established at the lowest of the following six (6) limitations:
(1) MAL applies to all providers covered by this rule. The limitation shall be computed using forecasted data submitted by providers for rate reviews on a statewide basis for facilities providing assistance to residents in county homes program (ARCH) and room and board assistance program (RBA) maintenance service. For residential facilities licensed under IC 16-28-2, the MAL is an amount that shall be one hundred thirty percent (130%) of the average allowable cost of facilities licensed under IC 16-28-2, weighted by beds. For facilities not licensed under IC 16-28-2, the MAL is an amount that shall be one hundred thirty percent (130%) of the average allowable cost of residential facilities not licensed under IC 16-28-2, weighted by beds. The average allowable cost shall be maintained by the division, and a revision shall be made to this rate limitation four (4) times per year effective on March 1, June 1, September 1, and December 1.
(2) ~~Either of the following:~~
~~(A)~~ The calculated rate for facilities licensed under IC 16-28-2 is the sum of the allowed per diem costs, plus the allowed profit

add-on payment. The profit add-on is equal to thirty-five percent (35%) of the difference between a provider's allowed per diem cost and ~~fifty-two~~ **forty-six** percent ~~(52%)~~ **(46%)** of the average daily rate of reimbursement paid under IC 12-15-14 for ~~intermediate care~~ **nursing** facilities licensed under IC 16-28, weighted by beds, if that difference is greater than zero (0). The calculated rate for facilities that are not licensed under IC 16-28 is the sum of the allowed per diem costs.

~~(B) Notwithstanding clause (A), the fifty-two percent (52%) of the average daily rate of reimbursement paid under IC 12-15-14 for intermediate care facilities licensed under IC 16-28, weighted by beds, will be replaced with a percentage of the nursing facility average daily case mix rate, weighted by beds, for calculating the profit add-on, once the rule adopted by the office of Medicaid policy and planning establishing a case mix reimbursement methodology for Medicaid-enrolled nursing facilities is implemented. The percentage of the nursing facility average daily case mix rate, weighted by beds, shall be calculated in accordance with subdivision (6)(B).~~

(3) The maximum allowable annual rate increase shall not be greater than the average rate of change, expressed as a decimal, of the most recently reported eight (8) quarters of historical data plus the most recently reported four (4) quarters of forecasted data of the Gross National Product Implicit Price Deflator. The maximum rate allowed by the annual rate increase limitation shall be applicable to any rate established during the twelve (12) month period between annual rate reviews. The maximum rate allowed by the annual rate increase limitation shall be equal to the rate in effect immediately prior to the rate effective date of the annual rate review, times the sum of one (1), plus the maximum allowable annual rate increase applicable at the rate effective date of the annual rate review.

(4) In no instance shall the approved rate be higher than the rate paid to that provider by the general public for the same type of services.

(5) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(6) ~~Either of the following:~~

~~(A)~~ The rate may not exceed ~~fifty-two~~ **forty-six** percent ~~(52%)~~ **(46%)** of the average daily rate of reimbursement paid under IC 12-15-14 for ~~intermediate care~~ **nursing** facilities licensed under IC 16-28, weighted by beds.

~~(B) Notwithstanding clause (A), once the rule adopted by the office of Medicaid policy and planning establishing a case mix reimbursement methodology for Medicaid-enrolled nursing facilities is implemented, the fifty-two percent (52%) of the average daily rate of reimbursement paid under IC 12-15-14 for intermediate care facilities licensed under IC 16-28, weighted by beds, will be replaced with the closest whole percentage of the nursing facility average daily case mix rate, weighted by beds, that approximates the fifty-two percent (52%) of the average daily rate of reimbursement paid under IC 12-15-14 for intermediate care facilities licensed under IC 16-28, weighted by beds. The percentage of the nursing facility average daily case mix rate, weighted by beds, will be calculated on the first quarter following the effective date establishing a case mix rate of reimbursement and remain a fixed percentage for all subsequent quarters.~~

~~(b) The rate for private rooms and the rate for three (3) bed or more rooms shall be calculated using the ratio or percentage spread of the proposed private pay rates for those types of beds times the two (2) bed rate, subject to the other limitations of this section.~~

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-9; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2203; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3055; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1121; filed Feb 6, 1998, 10:30 a.m.: 21 IR 2079; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1347)

SECTION 6. 460 IAC 1-3-10 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-8-6; IC 12-10-6; IC 12-15; IC 16-28-2; IC 24-4.6-1-101

Sec. 10. (a) ~~A two (2) bed room rate, which is~~ The ~~basic~~ per diem room rate shall be established as a ratio between total allowable costs and resident days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Resident maintenance costs shall be clearly identified.

(c) The provider shall report as resident maintenance costs only costs that have been incurred in the providing of resident maintenance services. The provider shall certify on all financial reports that costs not related to resident maintenance have been separately identified on the financial report.

(d) In determining reasonableness of costs, the division may compare line items, cost centers, or total costs of providers statewide. The division may request satisfactory documentation from providers whose costs do not appear to be reasonable.

(e) The division's test of reasonableness shall consist of three (3) levels of review. Each level is based on a professional analysis of forecasted data. These levels of review are as follows:

(1) The first level of review is a general line item review. In this step, the rate setter will review each forecasted line item for reasonableness based upon comparison with the previous annual financial report and consideration of current economic conditions. If an exceptional line item is not adequately supported, even when taking into account possible misclassification by the provider, the line item shall be adjusted to the annual financial report per diem cost that has been inflated according to this rule.

(2) The second level of review is a comparison of forecasted per diem cost by cost center and in total to annual financial report data. This step is performed only on those budgets that are above the seventy-fifth percentile in total routine per diem cost. It also takes into account previous rate setter adjustments made under the general line item review in subdivision (1). When an exceptional cost center per diem amount is not adequately supported, it shall be adjusted to the inflated per diem cost of the annual financial report according to this rule.

(3) The third level of review is a cost center comparison of the provider's forecasted per diem cost to allowed per diem cost of other providers statewide, excluding adjustments made under this subdivision, in the resident care information system (RCIS) class. The RCIS class used for this purpose contains enrolled providers throughout Indiana that provide resident care. As an upper limit, the division will adjust the cost center to reflect the following ceilings for each cost center in the RCIS classification:

(A) Dietary: ninetieth percentile.

(B) Laundry and housekeeping: ninetieth percentile.

(C) Plant operations: seventy-fifth percentile.

(D) General and administrative: seventy-fifth percentile.

(E) Employee benefits: seventy-fifth percentile.

(F) Health related services: ninetieth percentile.

(G) Activities programs: ninetieth percentile.

Health related services and activities programs apply only to enrolled providers licensed under IC 16-28-2. For enrolled providers not licensed under IC 16-28-2, costs for health related services and activities programs are not allowable and shall not be utilized in the calculation of the percentile limitation. In addition, the costs of health related services provided to individuals eligible for Medicaid under IC 12-15 and applicable rules and for which the facility receives Medicaid reimbursement shall not be allowable. The data base used to calculate the ceilings for the health related services and the activities program cost centers shall include only those residential facilities licensed under IC 16-28-2.

(f) Other services, except health related services and activities programs that are subject to the percentile limitations in this section, shall be considered allowable costs.

(g) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-10; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2204; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3056; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1348)*

SECTION 7. 460 IAC 1-3-13 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-13 Allowable cost; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 13. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee

will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:
(1) the original loan balance at the time of acquisition;
(2) eighty percent (80%) of the historical cost of the facilities and equipment; or
(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the ~~average yield to maturity of the Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily~~ **U.S. Treasury Bond, thirty (30) year amortization, constant maturity** rate **plus three percent (3%)** rounded to the nearest one-half percent (.5%) or the actual interest rate, whichever is lower. The date that the financing commitment was signed by the lender and borrower shall be fixed as the date upon which the allowable rate shall be determined.

(e) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing shall not be recognized until eight (8) years after the date of the original mortgage. Refinancing arrangements entered into after eight (8) years shall only be recognized for sums up to seventy-five percent (75%) of the historical cost, and interest rates on the refinancing shall not be allowable in excess of the interest rate limit established on the date the commitment was signed and the interest rate fixed by the lender and borrower.

(f) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (e).

(g) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(h) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of the lesser of proposed revenues or proposed occupancy times the maximum allowable annual rate increase if applicable, otherwise the proposed assistance to residents ~~of~~ **in** county homes (ARCH) and room and board assistance (RBA) rate. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(i) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than resident care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(j) Loans from a related party must be identified and reported separately on the annual financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(k) Use fee for variable interest rate mortgages will be calculated as follows:
(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.
(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).
(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.
(4) The use fee on the prospective rate is the amount forecasted in subdivision (3) plus or minus the variance in subdivision (2).
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-13; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2205; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1349)

SECTION 8. 460 IAC 1-3-14 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-14 Allowable costs; capital return factor; computation of return on equity component
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 14. (a) The return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(b) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the ~~average yield to~~ **U.S. Treasury Bond, thirty (30) year amortization, constant** maturity **rate plus three percent (3%)** on the last day of the reporting period, ~~of the Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily rate,~~ whichever is higher. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-14; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2206; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1350)*

SECTION 9. 460 IAC 1-3-15 IS AMENDED TO READ AS FOLLOWS:

460 IAC 1-3-15 Allowable costs; capital return factor; use fee; depreciable life; property basis
Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis Property Category	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7-1-76	$10,120
4-1-77	$10,604
10-1-77	$10,956
4-1-78	$11,264
10-1-78	$11,704
4-1-79	$12,232
10-1-79	$12,892
4-1-80	$13,288
10-1-80	$13,992
4-1-81	$14,696
10-1-81	$15,312
4-1-82	$15,752
9-1-82	$16,000
3-1-83	$16,080
9-1-83	$16,480
3-1-85	$16,960
9-1-85	$16,960
3-1-86	$17,120
9-1-86	$17,200
3-1-87	$17,520
9-1-87	$17,920
3-1-88	$18,080
9-1-88	$18,400
3-1-89	$18,480

9-1-89	$18,640
3-1-90	$18,880
9-1-90	$19,120
3-1-91	$19,600
9-1-91	$19,760

The schedule shall be updated semiannually effective on March 1 and September 1 by the division and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The maximum capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is computed on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date;

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired on or before April 1, 1983; and

(C) the allowable interest rate per bed is the ~~Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily~~ **U.S. Treasury Bond, thirty (30) year amortization, constant maturity** rate **plus three percent (3%)** rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is computed on:

(A) the allowable equity as defined under section 14 of this rule;

(B) the rate of return on equity is the greater of the ~~Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily~~ **U.S. Treasury Bond, thirty (30) year amortization, constant maturity** rate **plus three percent (3%)** rounded to the nearest one-half percent (.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the ~~Federal Home Loan Mortgage Corporation, whole loan purchase, multifamily~~ **U.S. Treasury Bond, thirty (30) year amortization, constant maturity** rate **plus three percent (3%)** rounded to the nearest one-half percent (.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs**,** which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the ~~Indiana Medicaid~~ **Assistance to Residents in County Homes** program **and the Room and Board Assistance program,** shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-15; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2207; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1350)

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