Rate Rationalization for Community Residences (CRs) / Individualized Residential Alternatives (IRAs) Habilitation and Day Habilitation

Effective date: 4/22/15

SUMMARY OF EXPRESS TERMS

The proposed regulations amend the newly-adopted 10 NYCRR Subpart 86-10, concerning the rate methodology for Residential Habilitation delivered in IRAs and Community Residences and Day Habilitation. The amendments contain the methodology as described in the regulations adopted July 1, 2014 with changes required by the federal Centers for Medicare and Medicaid Services (CMS) subsequent to the adoption of those regulations. The amendments change the SSI offset with additional changes to the budget neutrality factor necessitated by the change in the SSI offset. The changes are:

1) A definition was added for "state supplement." The state supplement is the amount paid to a provider to cover room and board costs in excess of SSI/SNAP payments.

2) The "budget neutrality" formula was changed for Supervised and Supportive Individualized Residential Alternatives (IRAs) and Community Residences (CRs). The method for calculating the budget neutrality factor for the "state supplement" was adjusted.

3) The "capital component" sections were revised to eliminate capital threshold schedules and require that capital costs must be depreciated over 25 years. The amendments require day habilitation providers to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount approved by OPWDD, and to have an

independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule.

4) The amendments also contain provisions to reimburse IRA and CR providers for July 1 through November 1, 2014 for the difference between the November 1, 2014 rate and the July 1, 2014 rate, if the November 1 rate is higher.

5) The amendments change the methodology to include funding for a 2% increase for direct support staff on January 1, 2015 and April 1, 2015, as well as a 2% increase for clinical staff on April 1, 2015 for eligible programs.

6) Several non-substantive technical corrections were added to correct reference errors and grammatical errors.

Pursuant to the authority vested in the Commissioner of Health by section 201 of the Public Health Law, Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register to read as follows:

86-10. Rates for Non-State Providers of Residential Habilitation in Community Residences, Including Individualized Residential Alternatives (IRAs) and for Non-State Providers of Day Habilitation.

86-10.1 – Applicability - On and after November first[July first], two thousand fourteen, rates of reimbursement for residential habilitation services provided in community residences, including IRAs, and for day habilitation services, other than those provided by the Office for People with Developmental Disabilities, shall be determined in accordance with this Subpart.

86-10.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

(a) Allowable capital costs. Capital costs that are allowable under 14 NYCRR Subpart 635-6.

(b) Allowable operating costs. In the case of residential habilitation services, operating costs that are allowable under 14 NYCRR paragraph[sections] 635-10.4 (b)(1) and subdivision 686.13(b); in the case of day habilitation services, operating costs that are allowable under 14 NYCRR paragraph[section] 635-10.4(b)(2).

(c) Acuity factor. Factor developed through a regression analysis utilizing components of Developmental Disabilities Profile (DDP) scores, average residential bed size, Willowbrook

class indicators and historical utilization data to predict direct care hours needed to serve individuals.

(d) Base year. The consolidated fiscal report period from which the initial period rate will be calculated. Such period shall be January first, two thousand eleven through December thirty-first, two thousand eleven for providers reporting on a calendar year basis and July first, two thousand ten through June thirtieth, two thousand eleven for providers reporting on a fiscal year basis.

(e) Base operating rate. Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June thirtieth, two thousand fourteen.

(f) Community residence. A facility operated as a community residence under 14 NYCRR Part 686, including an individualized residential alternative.

(g) Day habilitation services. Day habilitation services provided under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.

(h) Department of Health (DOH) Regions. Regions as defined by the Department, assigned to providers based upon the geographic location of the provider's headquarters as reported on the consolidated fiscal report. Such regions are as follows:

(1) Downstate: 5 boroughs of New York City, Nassau, Suffolk, Westchester;

(2) Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;

(3) Upstate Metro: Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming;

(4) Upstate Non-Metro: Any counties not listed in [sub]paragraphs (1), (2) or (3) of this subdivision [paragraph].

(i) Developmental Disabilities Profile (DDP-2). The document titled *Developmental Disabilities Profile (DDP-2)* dated 7/10 and issued by OPWDD. This document, the *Developmental Disabilities Profile (DDP-2) User's Guide* and another document titled *Scoring the DDP* are [is] available during business hours and by appointment at the following locations:

(1) the Department of State, Division of Administrative Rules, One Commerce Plaza, 99 Washington Avenue, Albany NY 12231-0001

(2)OPWDD, Attention Public Access Officer, 44 Holland Avenue, Albany, NY 12229.

(j) Evacuation Score (E-Score). The score for a supervised community residence that is certified under Chapters 32 or 33 of the Residential Board and Care Occupancies of the NFPA 101 *Life Safety Code* (2000 edition) that is provided to the Department by OPWDD once a year. The E-score is described in the NFPA 101A *Guide on Alternative Approaches to Life Safety*, 2001 edition. The *Life Safety Code* and *Guide on Alternative Approaches to Life* Safety are is available from the National Fire Protection Association, One Batterymarch Park, Quincy, MA 02169-7471; or is available during business hours and by appointment at the following locations:

(1) the Department of State, Division of Administrative Rules, One Commerce Plaza, 99 Washington Avenue, Albany, NY 12231-0001

(2) OPWDD, Attention Public Access Officer, 44 Holland Avenue, Albany, NY 12229.

(k) E-Score Factor. Factor derived from analysis of Evacuation Scores to adjust staffing needs necessary to address health and safety needs.

(l) Financing expenditures. Interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property.

(m) Individual. Person receiving a residential or day habilitation service.

(n) Initial period. July first, two thousand fourteen through June thirtieth, two thousand fifteen.

(o) Lease/rental and ancillary payments. A provider's annual rental payments for real property and ancillary outlays associated with the property such as utilities and maintenance.

(p) Occupancy factor. Beginning July first, two thousand fifteen such factor will be an adjustment made prospectively at the beginning of the applicable rate year, based upon the previous years' experience. Such adjustment shall be provider specific and shall be the lower of the provider's actual vacancy or five percent.

(q) Operating costs. Provider costs related to the provision of day habilitation and residential habilitation services provided in a community residence and identified in such provider's cost reports. With the exception of Live-In Caregiver services, allowable operating costs shall not include the costs of board.

(r) Provider - An individual, corporation, partnership or other organization to which OPWDD has issued an operating certificate [pursuant to Article 16 of the Mental Hygiene Law] to operate a community residence, and for which the NYS Department of Health has issued a Medicaid provider agreement, or an individual, corporation, partnership or other organization to which OPWDD has issued an operating certificate [pursuant to article 16 of the Mental Hygiene Law] or approval to operate a day habilitation program, and for which the NYS Department of Health has issued a Medicaid provider agreement.

(s) Rate sheet capacity. The number of individuals for whom a provider is certified or approved by OPWDD to provide residential habilitation.

(t) Reimbursable cost. The final allowable costs of the rate year after all audit and/or adjustments are made. [Reimbursable cost will be reduced by any rent and other charges as described in 14 NYCRR 671.7.]

(u) Residential habilitation. Residential habilitation services provided in a community residence, under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10 and 14 NYCRR 671.

(v) Room and board. Room means hotel or shelter type expenses including all property related costs such as rental or depreciation related to the purchase of real estate and furnishings; maintenance, utilities and related administrative services. Board means three meals a day or any other full nutritional regimen.

(w) Start-up costs. Those costs associated with the opening of a new program. Start-up costs include pre-operational rent, utilities, staffing, staff training, advertising for staff, travel, security services, furniture, equipment and supplies.

(x) State supplement. Amount paid to a provider to cover Room and Board costs in excess of SSI and Supplemental Nutrition Assistance Program (SNAP) payments.

(y) Target rate. The final rate in effect at the end of the transition period for each waiver service determined using the rate year final reimbursable cost for each respective provider for each respective service divided by the final total of actual units of service for all individuals, regardless of payor.

(z) Units of service. The unit of measure for the following waiver services shall be:

(1) Residential habilitation provided in a supervised community residence - daily

(2) Residential habilitation provided in a supportive community residence - monthly

(3) Day habilitation - daily

86-10.3. Rates for residential habilitation services and for day habilitation services.

(a) There shall be one provider-wide rate for each provider of residential habilitation service and one provider-wide rate for each provider of day habilitation services, except that rates for residential habilitation or day habilitation services provided to individuals identified as specialized populations by OPWDD shall be determined under section 86-10.8 of this Subpart. Adjustments may be made to the rate resulting from any final audit findings or reviews.

(b) Rates shall be computed on the basis of a full twelve month base year CFR, adjusted in accordance with the methodology as provided in this section. The rate shall include operating cost components, facility cost components and capital cost components as identified in applicable subdivisions. Such base year may be updated periodically, as determined by the Department.

(c) Components of rates for residential habilitation provided in supervised community residences.

(1) Operating component. The operating component shall be based on allowable operating costs identified in the consolidated fiscal reports. The operating component shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation- supportive IRA, day habilitation services and intermediate care facility

for the developmentally disabled services (ICF/DD), divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, such sum to be divided by base year salaried direct care dollars for each provider [of]in a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider [of]in a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care dollars of all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and agency administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for the base year for each provider in a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph

(i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional average general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits for the base year for each provider, divided by base year salaried direct care dollars of a provider, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment , other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for a provider. Such sum shall be divided by the base year salaried direct care dollars of such provider and such

quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and agency administration allocation for the base year for a provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for the base year for a provider). The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of

this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Statewide average direct care hours per person, which shall mean the total salaried and contracted direct care hours for the base year for all providers divided by total capacity for all providers, as such capacity is determined from the rate sheets for the base year and as pro-rated for partial year sites.

(xiv) Statewide average direct hours per provider, which shall mean the product of the statewide average direct care hours per person, as determined pursuant to subparagraph (xiii) of this paragraph, the applicable E-Score factor of a provider, the applicable provider acuity factor and the applicable provider rate sheet capacity for the base year, as pro-rated for partial year sites.

(xv) Statewide budget neutrality adjustment factor for hours, which shall mean the quotient of the total salaried and contracted direct care hours for the base year for all providers, divided by the total of statewide average direct hours for all providers as determined pursuant to subparagraph (xiv) of this paragraph.

(xvi) Calculated direct care hours, which shall mean the product of the statewide average direct care hours per provider, as determined pursuant to subparagraph (xiv) of this paragraph, and the statewide budget neutrality adjustment factor for hours, as determined pursuant to subparagraph (xv) of this paragraph. Such product shall then

be divided by the rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xviii) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of a provider.

(xix) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of a provider, divided by the rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by the rate sheet capacity for the initial period for such provider.

(xx) Regional average contracted clinical hourly wage, which shall mean the quotient of base year contracted clinical dollars of [a]each provider in a DOH region divided by the base year contracted clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region.

(xxi) Provider contracted clinical hours, which shall mean the quotient of base year contracted clinical hours of a provider divided by rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by rate sheet capacity for the initial period.

(xxii) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined

pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths..

(xxiii) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xviii) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by twenty-five hundredths.

(xxiv) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xvi) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xxii) of this paragraph.

(xxv) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xix) of this paragraph and the provider clinical hourly wage- adjusted for wage equalization factor, as determined pursuant to subparagraph (xxiii) of this paragraph.

(xxvi) Provider reimbursement for contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xxi) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xx) of this paragraph.

(xxvii) Provider operating revenue, which shall mean the sum of the provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxiv) of this paragraph, the provider reimbursement from clinical hourly wage, as

determined pursuant to subparagraph (xxv) of this paragraph, and the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxvi) of this paragraph.

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

(xxix)Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvii) of this paragraph, and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of this paragraph.

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, [as subject to adjustments made in paragraph (6) of this subdivision]<u>as determined pursuant to subparagraph (xxix) of this paragraph</u>, by the applicable rate sheet capacity for the initial period and such quotient to be further divided by three hundred sixty-five, or three hundred sixty-six in the case of a leap year.

(2) Alternative operating cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services for the base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision, and the

applicable regional average direct care hours, which shall mean the quotient of salaried and contracted direct care hours for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider [of]in a DOH region, aggregated for all such providers in such region divided by three hundred sixty-five, or three hundred sixty-six in the case of a leap year.

(ii) The product [should]shall then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider [of]in a DOH region, aggregated for all such providers in such region divided by three hundred sixty-five, or three hundred sixty-six, in the case of a leap year.

Such sum shall be multiplied by the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of paragraph (1) of this subdivision to determine the final regional daily operating rate.

(3) Facility cost component. The facility cost component shall include allowable facility costs identified in the consolidated fiscal reports, and shall be inclusive of the following components:

(i) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone,

lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property, for the base year for a provider divided by rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(ii) The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by twelve.

(4) Alternative facility cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services provided in a supervised community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial period. [Such product shall be multiplied by the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of paragraph (3) of this subdivision and] The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by twelve.

(5) Capital component.

(i) [General principles.] Capital costs shall be [included in the rate at the lower of the amount] determined pursuant to 14 NYCRR Subpart 635-6. [or thresholds as determined pursuant to subparagraph (iv) of this paragraph. The Department may retroactively adjust the capital component.]

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July first, two thousand fourteen.

(ii) Initial rate. The rate shall include the approved appraised costs of an [lease or] acquisition or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of the site [such costs], continuing until such time as actual costs are submitted to the State[office for people with developmental disabilities. The amount included in the rate shall not exceed the regional threshold rates for such period.] Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the State [office for people with developmental disabilities] within two years from the date of certification [of estimated costs], the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

(iii) Cost verified rates. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the [office for people with developmental disabilities and] supporting documentation of such costs[shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department]. A provider

submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider.[Under no circumstances shall the amount included in the rate under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph.] Capital costs approved on or after November first, two thousand fourteen shall[may] be amortized over a twenty-five[maximum fifteen] year period for acquisition of properties or the life of the lease for leased sites[, but in no circumstance shall the amortization exceed the length of the loan taken]. Amortization shall begin upon certification by the provider of such costs. For community residences start-up costs may be amortized over a one year period beginning with site certification.

[Limitations on reimbursement for such costs shall be the following:]

[(*a*) Allowable acquisition, rehabilitation and new construction costs shall be determined in accordance with 14 NYCRR Subpart 635-6. Acquisition costs are limited to the appraised value and acquisition and construction cannot exceed regionally based thresholds.]

[(*b*) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.]

[(*c*) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.]

[(*d*) Design fees. Design fees may not exceed five percent above the fee schedule.]

[(*e*) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate. Mortgages that do not amortize over the nominal mortgage term are not allowable.]

[(*f*) Lease costs. Allowable lease costs shall be determined in accordance with 14 NYCRR Part 635-6.]

[(*g*) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs are not included.]

[(*h*) Other costs. Maximum of $20,000. Other costs may include but are not limited to legal and accounting fees.]

[(*i*) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed $10,000.]

[(*j*) Purchase options. Limited to twelve months in length with a maximum of $15,000 in cost.]

[(*k*) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.]

[(*l*) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works, security, and bank site inspection.]

[(iv) Thresholds. Thresholds shall be determined pursuant to the following:]

[Residential rental sites]

[*Threshold for Residential Rental sites- leases less than 5-year term*]				
[Counties]	[certified capacity of 1]	[certified capacity of 2]	[certified capacity of 3]	[Each Increase in Certified Capacity by 1]
[Orange, Rockland, Putnam, Dutchess, Ulster]	[$11,692]	[$13,853]	[$16,903]	[$3,050]
[Nassau, Suffolk and Westchester Counties]	[$15,251]	[$18,809]	[$22,495]	[$3,686]
[New York City except Manhattan]	[$21,351]	[$24,909]	[$28,468]	[$3,558]
[Manhattan]	[$28,341]	[$32,153]	[$35,585]	[$3,431]
[All other Counties]	[$9,023]	[$10,548]	[$12,200]	[$1,652]
[*Heat Allowance*	[*+ $900*]	[*+$1,200*]	[*+$1,500*]	[*4 or more*

For rentals which include Heat]				*+$1,500 +$300 additional*]

[*Threshold for leases greater than 5 years*]	
[New York City]	[$13,217 per bed]
[Westchester, Nassau, Rockland and Suffolk Counties]	[$10,548 per bed]
[Putnam, Orange, Dutchess and Ulster Counties]	[$7,752 per bed]
[Upstate (all other counties)]	[$5,465 per bed]

[Allowable renovation costs for new/relocating residential sites with leases less than 5- year term]

[*Renovation costs for residential leases less than 5 years*]	
[Counties]	[Threshold]
[New York City and the counties of Suffolk, Rockland Nassau, Westchester, Putnam, Orange, Dutchess and Ulster]	[Contract Costs for Renovation: The lesser of $5,000 per bed, or $25,000 per unit,]
	[Contingency Allowance: where required by contract, an additional allowance for

	contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost.]
[All other Counties]	[Contract Costs for Renovation: The lesser of $3,000 per bed, or $15,000 per unit]
	[Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost]

[Capital Thresholds for Residential Acquisitions- New or Relocation

(including Condominium and Cooperative Apartments)]

[County]	[Capital Threshold Cost per Bed]
[Manhattan]	[$228,161]
[Bronx, Kings, Queens, Richmond, Nassau and Westchester]	[$159,182]
[Putnam, Rockland, Suffolk]	[$135,424]
[Columbia, Dutchess, Orange, Sullivan, Ulster]	[$117,605]

[Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren]	[$84,343]
[Upstate (all other)]	[$77,622]

[Renovation costs in existing sites]

[County]	[Renovation Threshold - Existing Sites Cost per bed]
[Manhattan]	[$ 114,081]
[Bronx, Kings, Queens, Richmond, Nassau and Westchester]	[$ 79,591]
[Putnam, Rockland, Suffolk]	[$ 67,712]
[Columbia, Dutchess, Orange, Sullivan, Ulster]	[$ 58,803]
[Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren]	[$ 42,172]
[Upstate (all other)]	[$ 38,811]

[Residential Start-Up Allowance]

[*Residential Start-up Allowance per bed*]		
[Counties]	[New]	[Relocations]
[New York City, Suffolk, Nassau, Westchester, Putnam,	[$5,800]	[$1,000]

Rockland]		
[Rest of the State]	[$5,500]	[$900]

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[Pre-Operational Rent Allowance]

[*Pre-operational rent allowance*]		
[Program type]	[Without Renovations]	[With Renovations]
[Pre-operational rent allowance]	[1 month]	[3 months]

[Design Fees]

[Approved Construction Costs]	[Design Fee]	
[0 to $15,000]	[$3,000]	[Subject to OPWDD approval]
[$15,001 to $50,000]	[$3,000]	[Plus 17.50% of cost over $15,000]
[$50,001 to $100,000]	[$9,125]	[Plus 15.50% of cost over $50,000]
[$100,001 to $150,000]	[$16,875]	[Plus 12.50% of cost over $100,000]

[$150,001 to $200,000]	[$23,125]	[Plus 10.00% of cost over $150,000]
[$200,001 to $250,000]	[$28,125]	[Plus 8.0% of cost over $200,000]
[$250,001 to $300,000]	[$32,125]	[Plus 4.75% of cost over $250,000]
[$300,001 to $350,000]	[$34,500]	[Plus 10.80% of cost over $300,000]
[$350,001 to $400,000]	[$39,900]	[Plus 10.60% of cost over $350,000]
[$400,001 to $450,000]	[$45,200]	[Plus 10.40% of cost over $400,000]
[$450,001 to $500,000]	[$50,400]	[Plus 10.20% of cost over $450,000]
[$500,001 to $550,000]	[$55,500]	[Plus 10% of cost over $500,000]
[$550,001 to $600,000]	[$60,500]	[Plus 9.80% of cost over $550,000]
[$600,001 to $650,000]	[$65,400]	[Plus 9.60% of cost over $600,000]
[$650,001 to $700,000]	[$70,200]	[Plus 9.40% of cost over $650,000]
[$700,001 to		[Plus 9.20% of cost over

$750,000]	[$74,900]	$700,000]
[$750,001 to $1,000,000]	[$79,500]	[Plus 10.20% of cost over $750,000]
[$1,000,001 to $1,500,000]	[$105,000]	[Plus 9.90% of cost over $1,000,000]
[$1,500,001 to $2,000,000]	[$154,500]	[Plus 9.90% of cost over $1,500,000]
[$2,000,001 to $2,500,000]	[$204,000]	[Plus 9.20% of cost over $2,000,000]
[$2,500,001 to $3,000,000]	[$250,000]	[Plus 7.60% of cost over $2,500,000]
[$3,000,001 to $3,500,000]	[$288,000]	[Plus 7.50% of cost over $3,000,000]
[$3,500,001 to $4,000,000]	[$325,500]	[Plus 6.90% of cost over $3,500,000]
[$4,000,001 to $4,500,000]	[$360,000]	[Plus 6.30% of cost over $4,000,000]
[$4,500,001 to $5,000,000]	[$391,500]	[Plus 5.70% of cost over $4,500,000]
[$5,000,001 to $5,500,000]	[$420,000]	[Plus 5.10% of cost over $5,000,000]
[$5,500,001 to $6,000,000]	[$445,500]	[Plus 4.50% of cost over $5,500,000]

[$6,000,001 to $7,000,000]	[$468,000]	[Plus 5.70% of cost over $6,000,000]
[$7,000,001 to $8,000,000]	[$525,000]	[Plus 3.50% of cost over $7,000,000]
[$8,000,001 to $9,000,000]	[$566,000]	[Plus 2.50% of cost over $8,000,000]
[$9,000,001 to $9,999,999]	[$585,000]	[Plus 1.50% of cost over $9,000,000]

[Soft costs]

[*Limited to the lesser of actual cost or threshold*]
[Site survey $500 for existing site or $5,000 (new construction)]
[Builders risk insurance $2,000 for existing site, or $4,000 (new construction)]
[Property casualty insurance $2,000]
[Bank site inspection $5,100 (new construction)]
[Performance Bond at 3% of the approved rehabilitation costs over $99,999]
[Soil inspection at amount approved by OPWDD]
[Clerk of the works at amount approved by OPWDD]
[Security at amount approved by OPWDD]

[(*a*) Capital Review Thresholds for Residential Leased Space – Apartments (Lease term is less than 5 years) For apartment leases of five years or less, the thresholds are applied against the annual rent costs excluding any ancillary costs identified in the lease that are required to be paid to the landlord for services such as lawn care or maintenance. The average annual rent cost is calculated by multiplying the average monthly rent for the entire period of the lease by twelve. The annual property amount included in the rate is the lesser of their actual rental costs or the threshold rate, subject to the limitations in 14 NYCRR Subpart 635-6. Actual ancillary lease costs that are required to be paid to the landlord for services shall be included in the rate.[

[(*b*) Costs of residential acquisitions are included in the rate at the lesser of the provider's actual cost, or the thresholds. The threshold includes the costs of building, land and rehabilitation costs (excluding contingency).]

[(*c*) For renovation costs in existing leased sites, allowable costs are limited to the lesser of the provider's actual costs or the threshold values listed. In addition, where approved by OPWDD, the provider is eligible for an additional allowance for contingency funds to address renovation cost overages with a limit of the lesser of actual cost overage or ten percent of the contract cost.]

(iv) Renovations of existing provider owned residential programs shall be funded through the Residential Reserve for Replacement (RRR).

(6) Adjustments. Rates described in this subdivision shall be subject to a reimbursement offset. Such offset shall be determined as follows:

(i) The sum of the total provider facility reimbursement[revenue], as determined by subparagraph (i) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

(ii) Supplemental security income, as determined by 14 NYCRR 671.7(b[a])(9)(xxii), annualized and multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by 14 NYCRR 671.7(b[a])(10)(i)(e[c]), and multiplied by twelve, such product to be multiplied by a provider's initial period rate sheet capacity.

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative, the State Supplement will be equal to zero[reimbursement offset amount will be added to a provider's total provider operating revenue adjusted, as calculated in paragraph (1), subparagraph (xxix) of this subdivision]. If such amount is positive, a provider shall receive the state supplement amount multiplied by the statewide budget neutrality factor for state supplement as calculated below.

(v) Statewide budget neutrality factor for state supplement, which shall mean the sum of the [Total reimbursement]State Supplement from all provider rate sheets in effect on June thirtieth, two thousand fourteen less [the sum of total provider operating revenue-adjusted as calculated in paragraph (1) subparagraph (xxix) of this subdivision plus reimbursement offset amount as calculated in subparagraph (iv) of this paragraph for all providers]six million dollars consistent with the savings plan developed by the workgroup established pursuant to Chapter 53 of the Laws of two

thousand thirteen, divided by the sum of the State Supplement for all providers, as calculated pursuant to subparagraph (iv) of this paragraph.

If the sum of the State Supplement from all provider rate sheets in effect on June thirtieth, two thousand fourteen is lower than the sum of the state supplement for all providers as calculated pursuant to subparagraph (iv) of this paragraph then the Statewide budget neutrality factor shall be applied. If such sum is greater, then no statewide budget neutrality factor for state supplement shall be applied.

(7) Adjustments for July first, two thousand fourteen through October thirty-first, two thousand fourteen. The Department shall calculate the amount of reimbursement each provider would have received for July first through October thirty-first, two thousand fourteen for services under the methodology described in the November first, two thousand fourteen amendments to this Subpart. The Department or OPWDD shall pay each provider the difference between such reimbursement and the amount the provider was entitled to receive under this Subpart in effect from July first to October thirty-first, two thousand fourteen.

(d) Components of rates for residential habilitation provided in supportive community residences.

(1) Operating component. The operating component shall be based on allowable operating costs identified in the consolidated fiscal reports, and shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential

habilitation- supportive IRA, day habilitation services and ICF/DD services, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation- supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, such sum to be divided by salaried direct care dollars for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider [of]in a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care dollars for all providers in a DOH region, and

then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and agency administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional <u>average</u> general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of salaried direct care dollars divided by the salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits of each provider, divided by a provider's salaried direct care dollars, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment , other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars of a provider. Such sum shall be divided by the salaried direct care dollars of such provider and such quotient shall be multiplied by

the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and agency administration allocation for a provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation_equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and_contracted clinical dollars for the base year for a provider). The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of

this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Statewide average direct care hours per person, which shall mean the total base year salaried and contracted direct care hours for all providers divided by total capacity for all providers, as such capacity is determined from the rate sheets for the base year and as pro-rated for partial year sites.

(xiv) Statewide average direct hours per provider, which shall mean the product of the statewide average direct care hours per person, as determined pursuant to subparagraph (xiii) of this paragraph, [the applicable E-Score factor of a provider,]the applicable provider acuity factor and the applicable provider rate sheet capacity for the base year, as pro-rated for partial year sites.

(xv) Statewide budget neutrality adjustment factor for hours, which shall mean the quotient of the total base year salaried and contracted direct care hours for all providers, divided by the total of statewide average direct hours for all providers, as determined pursuant to subparagraph (xiv) of this paragraph.

(xvi) Calculated direct care hours, which shall mean the product of the statewide average direct care hours per provider, as determined pursuant to subparagraph (xiv) of this paragraph, and the statewide budget neutrality adjustment factor for hours, as determined pursuant to subparagraph (xv) of this paragraph. Such product shall then

be divided by the rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region.

(xviii) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.

(xix) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of a provider, divided by the rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by the rate sheet capacity for the initial period for such provider.

(xx) Regional average contracted clinical hourly wage, which shall mean the quotient of base year contracted clinical dollars of [a]each provider in a DOH region, aggregated for all such providers in such region, divided by the base year contracted clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region.

(xxi) Provider contracted clinical hours, which shall mean the quotient of a provider's contracted clinical hours for the base year divided by rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by rate sheet capacity for the initial period.

(xxii) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths.

(xxiii) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xviii) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by twenty-five hundredths.

(xxiv) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xvi) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xxii) of this paragraph.

(xxv) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xix) of this paragraph and the provider clinical hourly wage- adjusted for wage equalization factor, as determined pursuant to subparagraph (xxiii) of this paragraph.

(xxvi) Provider reimbursement for contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xxi) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xx) of this paragraph.

(xxvii) Provider operating revenue, which shall mean the sum of the provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxiv) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxv) of this paragraph, and the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxvi) of this paragraph.

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

(xxix)Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvii) of this paragraph, and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of this paragraph.

The final monthly operating rate shall be determined by dividing the total provider operating revenue- adjusted, as determined pursuant to subparagraph (xxix) of this paragraph, by the applicable rate sheet capacity for the initial period and such quotient to be further divided by twelve.

(2) Alternative operating cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation provided in a supportive community residence for the base year, the final monthly operating rate shall be a regional monthly operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision, and the applicable regional average direct care hours, which shall mean the quotient of base year salaried and contracted direct care hours for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider [of]in a DOH region, aggregated for all such providers in such region divided by twelve.

(ii) The product [should]shall then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider [of]in a DOH region, aggregated for all such providers in such region divided by twelve.

Such sum shall be multiplied by the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of paragraph (1) of this subdivision to determine the final regional monthly operating rate.

(3) Facility cost component. The facility cost component shall include allowable facility costs identified in the consolidated fiscal reports and shall be inclusive of the following components:

(i) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone,

lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property from the base year, divided by rate sheet capacity for the base year, pro-rated for partial year sites and such sum multiplied by rate sheet capacity for the initial period.

(ii)The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by the applicable rate sheet capacity for the initial period and such quotient to be further divided by twelve.

(4) Alternative facility cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services provided in a supportive community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider [of]in a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial year. [Such product shall be multiplied by the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of paragraph (3) of this subdivision and]The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by the applicable rate sheet capacity for the initial period and such quotient to be further divided by twelve.

(5) Capital cost component.

(i) [General principles.] Capital costs shall be [included in the rate at the lower of the amount] determined under 14 NYCRR Subpart 635-6[or the thresholds determined pursuant to subparagraph (iv) of this paragraph. The Department may retroactively adjust the capital component].

Note: The provision of this paragraph do not apply to capital approved by OPWDD prior to July first, two thousand fourteen.

(ii) Initial rate. The rate shall include the approved appraised costs of an [lease or]acquisition or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of the site [such costs], continuing until such time as actual costs are submitted to the State[office for people with developmental disabilities. The amount included in the rate shall not exceed the regional threshold rates for such period.] Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the State[office for people with developmental disabilities] within two years from the date of site certification [of estimated costs], the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

(iii) Cost verified rates. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the [office for people with developmental disabilities and] supporting documentation of such costs[shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department]. A provider

submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider.[Under no circumstances shall the amount included in the rate under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph.] Capital costs approved on or after November first , two thousand fourteen shall[may] be amortized over a twenty-five[maximum fifteen] year period for acquisition of properties or the life of the lease for leased sites[, but in no circumstance shall the amortization exceed the length of the loan taken]. Amortization shall begin upon certification by the provider of such costs. For community residences start-up costs may be amortized over a one year period beginning with site certification. [Limitations on reimbursement for such costs shall be the following:]

[(*a*) Allowable acquisition, rehabilitation and new construction costs shall be determined in accordance with 14 NYCRR Subpart 635-6. Acquisition costs are limited to the appraised value and acquisition and construction cannot exceed regionally based thresholds.]

[(*b*) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.]

[(*c*) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.]

[(*d*) Design fees. Design fees may not exceed five percent above the fee schedule.]

[(*e*) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than 5% of the initial rate. Mortgages that do not amortize over the nominal mortgage term are not allowable.]

[(*f*) Lease costs. Allowable lease costs shall be determined in accordance with 14 NYCRR Subpart 635-6.]

[(*g*) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs are not included]

[(*h*) Other costs. Maximum of $20,000. Other costs may include but are not limited to legal and accounting fees.]

[(*i*) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed $10,000.]

[(*j*) Purchase options. Limited to twelve months in length with a maximum of $15,000 in cost.]

[(*k*) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.]

[(*l*) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works, security, and bank site inspection.]

[(iv) Thresholds. Thresholds shall be determined pursuant to the following:]

[Residential rental sites]

[*Threshold for Residential Rental sites- leases less than 5-year term*]

[Counties]	[certified capacity of 1]	[certified capacity of 2]	[certified capacity of 3]	[Each Increase in Certified Capacity by 1]
[Orange, Rockland, Putnam, Dutchess, Ulster]	[$11,692]	[$13,853]	[$16,903]	[$3,050]
[Nassau, Suffolk and Westchester Counties]	[$15,251]	[$18,809]	[$22,495]	[$3,686]
[New York City except Manhattan]	[$21,351]	[$24,909]	[$28,468]	[$3,558]
[Manhattan]	[$28,341]	[$32,153]	[$35,585]	[$3,431]
[All other Counties]	[$9,023]	[$10,548]	[$12,200]	[$1,652]
[*Heat Allowance*	[*+ $900*]	[*+$1,200*]	[*+$1,500*]	[*4 or more*

For rentals which include Heat]				*+$1,500 +$300 additional*]

[*Threshold for leases greater than 5 years*]	
[New York City]	[$13,217 per bed]
[Westchester, Nassau, Rockland and Suffolk Counties]	[$10,548 per bed]
[Putnam, Orange, Dutchess and Ulster Counties]	[$7,752 per bed]
[Upstate (all other counties)]	[$5,465 per bed]

[Allowable renovation costs for new/relocating residential sites with leases less than 5- year term]

[*Renovation costs for residential leases less than 5 years*]	
[Counties]	[Threshold]
[New York City and the counties of Suffolk, Rockland Nassau, Westchester, Putnam, Orange, Dutchess and Ulster]	[Contract Costs for Renovation: The lesser of $5,000 per bed, or $25,000 per unit,]
	[Contingency Allowance: where required by contract, an additional allowance for

	contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost.]
[All other Counties]	[Contract Costs for Renovation: The lesser of $3,000 per bed, or $15,000 per unit]
	[Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost]

[Capital Thresholds for Residential Acquisitions- New or Relocation (including Condominium and Cooperative Apartments).]

[County]	[Capital Threshold Cost per Bed]
[Manhattan]	[$228,161]
[Bronx, Kings, Queens, Richmond, Nassau and Westchester]	[$159,182]
[Putnam, Rockland, Suffolk]	[$135,424]
[Columbia, Dutchess, Orange, Sullivan, Ulster]	[$117,605]

[Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	[$84,343]
[Upstate (all other)]	[$77,622]

[Renovation costs in existing sites]

[County]	[Renovation Threshold - Existing Sites Cost per Bed]
[Manhattan]	[$ 114,081]
[Bronx, Kings, Queens, Richmond, Nassau and Westchester]	[$ 79,591]
[Putnam, Rockland, Suffolk]	[$ 67,712]
[Columbia, Dutchess, Orange, Sullivan, Ulster]	[$ 58,803]
[Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren]	[$ 42,172]
[Upstate (all other)]	[$ 38,811]

[Residential Start-Up Allowance]

[*Residential Start-up Allowance per bed*]		
[Counties]	[New]	[Relocations]
[New York City, Suffolk, Nassau, Westchester, Putnam, Rockland]	[$5,100]	[$1,000]

[Rest of the State]	[$4,900]	[$900]

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[Pre-Operational Rent Allowance]

[*Pre-operational rent allowance*]		
[Program type]	[Without Renovations]	[With Renovations]
[Pre-operational rent allowance]	[1 month]	[Up to 3 months]

[Design Fees]

[Approved Construction Costs]	[Design Fee]	
[$0 to $15,000]	[$3,000]	[Subject to OPWDD approval]
[$15,001 to $50,000]	[$3,000]	[Plus 17.50% of cost over $15,000]
[$50,001 to $100,000]	[$9,125]	[Plus 15.50% of cost over $50,000]
[$100,001 to $150,000]	[$16,875]	[Plus 12.50% of cost over $100,000]

[$150,001 to $200,000]	[$23,125]	[Plus 10.00% of cost over $150,000]
[$200,001 to $250,000]	[$28,125]	[Plus 8.0% of cost over $200,000]
[$250,001 to $300,000]	[$32,125]	[Plus 4.75% of cost over $250,000]
[$300,001 to $350,000]	[$34,500]	[Plus 10.80% of cost over $300,000]
[$350,001 to $400,000]	[$39,900]	[Plus 10.60% of cost over $350,000]
[$400,001 to $450,000]	[$45,200]	[Plus 10.40% of cost over $400,000]
[$450,001 to $500,000]	[$50,400]	[Plus 10.20% of cost over $450,000]
[$500,001 to $550,000]	[$55,500]	[Plus 10% of cost over $500,000]
[$550,001 to $600,000]	[$60,500]	[Plus 9.80% of cost over $550,000]
[$600,001 to $650,000]	[$65,400]	[Plus 9.60% of cost over $600,000]
[$650,001 to $700,000]	[$70,200]	[Plus 9.40% of cost over $650,000]
[$700,001 to		[Plus 9.20% of cost over

$750,000]	[$74,900]	$700,000]
[$750,001 to $1,000,000]	[$79,500]	[Plus 10.20% of cost over $750,000]
[$1,000,001 to $1,500,000]	[$105,000]	[Plus 9.90% of cost over $1,000,000]
[$1,500,001 to $2,000,000]	[$154,500]	[Plus 9.90% of cost over $1,500,000]
[$2,000,001 to $2,500,000]	[$204,000]	[Plus 9.20% of cost over $2,000,000]
[$2,500,001 to $3,000,000]	[$250,000]	[Plus 7.60% of cost over $2,500,000]
[$3,000,001 to $3,500,000]	[$288,000]	[Plus 7.50% of cost over $3,000,000]
[$3,500,001 to $4,000,000]	[$325,500]	[Plus 6.90% of cost over $3,500,000]
[$4,000,001 to $4,500,000]	[$360,000]	[Plus 6.30% of cost over $4,000,000]
[$4,500,001 to $5,000,000]	[$391,500]	[Plus 5.70% of cost over $4,500,000]
[$5,000,001 to $5,500,000]	[$420,000]	[Plus 5.10% of cost over $5,000,000]
[$5,500,001 to $6,000,000]	[$445,500]	[Plus 4.50% of cost over $5,500,000]

[$6,000,001 to $7,000,000]	[$468,000]	[Plus 5.70% of cost over $6,000,000]
[$7,000,001 to $8,000,000]	[$525,000]	[Plus 3.50% of cost over $7,000,000]
[$8,000,001 to $9,000,000]	[$566,000]	[Plus 2.50% of cost over $8,000,000]
[$9,000,001 to $9,999,999]	[$585,000]	[Plus 1.50% of cost over $9,000,000]

[Soft costs]

[*Limited to the lesser of actual cost of threshold*]
[Site survey $500 for existing site or $5,000 (new construction)]
[Builders risk insurance $2,000 for existing site, or $4,000 (new construction)]
[Property casualty insurance $2,000]
[Bank site inspection $5,100 (new construction)]
[Performance Bond at 3% of the approved rehabilitation costs over $99,999]
[Soil inspection at amount approved by OPWDD]
[Clerk of the works at amount approved by OPWDD]
[Security at amount approved by OPWDD]

[(*a*) Capital Review Thresholds for Residential Leased Space – Apartments (Lease term is less than 5 years) For apartment leases of five years or less, the thresholds are applied against the annual rent costs excluding any ancillary costs identified in the lease that are required to be paid to the landlord for services such as lawn care or maintenance. The average annual rent cost is calculated by multiplying the average monthly rent for the entire period of the lease by twelve. The annual property amount included in the rate is the lesser of their actual rental costs or the thresholds, subject to the limitations in 14 NYCRR Subpart 635-6. Actual ancillary lease costs that are required to be paid to the landlord for services shall be included in the rate.]

[(*b*) Costs of residential acquisitions are included in the rate at the lesser of the provider's actual cost, or the threshold. The threshold includes the costs of building, land and rehabilitation costs (excluding contingency).]

[(*c*) For renovation costs in existing leased sites, allowable costs are limited to the lesser of the provider's actual costs or the threshold values listed below. In addition, where approved by OPWDD, the provider is eligible for an additional allowance for contingency funds to address renovation cost overages with a limit of the lesser of actual cost overage or ten percent of the contract cost.]

(iv) Renovations of existing provider owned residential programs shall be funded through the Residential Reserve for Replacement (RRR).

(6) Adjustments. Rates described in this subdivision shall be subject to a reimbursement offset. Such offset shall be determined as follows:

(i) The sum of the total provider facility reimbursement [revenue], as determined by subparagraph (iii) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

(ii) Supplemental security income, as determined by 14 NYCRR 671.7(b[a]) (9) (xxii), annualized and multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by 14 NYCRR 671.7(b[a]) (10) (ii), and multiplied by twelve, such product to be multiplied by a provider's initial period rate sheet capacity.

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative, the state supplement will be equal to zero[reimbursement offset amount will be added to a provider's total provider operating-revenue-adjusted, as calculated in paragraph (1), subparagraph (xxix) of this subdivision]. If such amount is positive, a provider shall receive the state supplement amount multiplied by the statewide budget neutrality factor for state supplement as calculated below.

Statewide budget neutrality factor for state supplement, which shall mean the sum of the State Supplement[Total reimbursement] from all provider rate sheets in effect on June thirtieth, two thousand fourteen [less the sum of total provider operating revenue-adjusted as calculated in paragraph (1) subparagraph (xxix) of this subdivision plus reimbursement offset amount as calculated in subparagraph (iv) of this paragraph for all providers], divided by the sum of the State Supplement for all providers, as calculated pursuant to subparagraph (iv) of this paragraph.

If the sum of the State Supplement from all provider rate sheets in effect on June thirtieth, two thousand fourteen is lower than the sum of the state supplement for all providers as calculated pursuant to subparagraph (iv) of this paragraph then the Statewide budget neutrality factor shall be applied. If such sum is greater, then no statewide budget neutrality factor for state supplement shall be applied.

(7) Adjustments for July first, two thousand fourteen through October thirty-first, two thousand fourteen. The Department shall calculate the amount of reimbursement each provider would have received for July first through October thirty-first, two thousand fourteen for services under the methodology described in the November first, two thousand fourteen amendments to this Subpart. The Department or OPWDD shall pay each provider the difference between such reimbursement and the amount the provider was entitled to receive under this Subpart in effect from July first to October thirty-first, two thousand fourteen.

(e) Day habilitation – group and supplemental.

(1) Operating component. Allowable operating costs shall include costs identified in the consolidated fiscal reports and reimbursement for such costs shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation- supportive IRA, day habilitation services and ICF/DD services, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA,

residential habilitation- supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region, such sum to be divided by base year salaried direct care dollars for each provider [of]in a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider [of]in a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care dollars of all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as

determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and agency administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for the base year for each provider [of]in a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional

average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits for the base year for each provider, divided by base year salaried direct care dollars of a provider, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for a provider. Such sum shall be divided by the base year salaried direct care dollars of such provider and such quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and agency administration allocation for the base year for a provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for a provider) for the base year. The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program

support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Provider direct care hours, which shall mean the sum of base year salaried direct care hours and base year contracted direct care hours, such sum to be divided by the billed units for the base year. Such sum to be multiplied by rate sheet units for the initial period.

(xiv) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region.

(xv) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.

(xvi) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of a provider, divided by the billed units for the base year, such quotient to be multiplied by the rate sheet units for the initial period for such provider.

(xvii) Regional average contracted clinical hourly wage, which shall mean the quotient of contracted clinical dollars for each provider in a DOH region, aggregated for all such providers in such region, divided by the base year contracted clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region.

(xviii) Provider contracted clinical hours, which shall mean the quotient of a provider's contracted clinical hours for the base year divided by the billed units for the base year, such quotient to be multiplied by rate sheet units for the initial period.
(xix) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths.
(xx) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xv) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xiv) of this paragraph multiplied by twenty-five hundredths.
(xxi) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xiii) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xix) of this paragraph.
(xxii) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xvi) of this paragraph and the provider clinical hourly wage- adjusted for wage equalization factor, as determined pursuant to subparagraph (xx) of this paragraph.
(xxiii) Provider reimbursement from contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to

subparagraph (xviii) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xvii) of this paragraph.

(xxiv) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property the base year for a provider and such sum to be divided by provider billed units for the base year. Such sum to be multiplied by rate sheet units for the initial period.

(xxv) Provider to/from transportation reimbursement, which shall mean the quotient of the to/from transportation allocation for the base year divided by the provider billed units for the base year. Such quotient to be multiplied by rate sheet units for the initial period.

(xxvi) Provider operating revenue, which shall mean the sum of provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxii) of this paragraph, the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxiii) of this paragraph, the provider facility reimbursement, as determined pursuant to subparagraph (xxiv) of this paragraph, and provider to/from transportation reimbursement, as determined pursuant to subparagraph (xxv) of this paragraph.

(xxvii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of all provider rate sheets in effect on June thirtieth, two

thousand fourteen, divided by provider operating revenue, as determined pursuant to subparagraph (xxvi) of this paragraph, for all providers.

(xxviii) Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvi) of this paragraph and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvii) of this paragraph.

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, as determined by subparagraph (xxviii) of this paragraph, by the applicable provider rate sheet units for the initial period.

(2) Alternative operating component. For providers that did not submit a cost report or submitted a cost report that was incomplete for day habilitation services for the base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision and the applicable regional average direct care hours, which shall mean the quotient of salaried and base year contracted direct care hours for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region; and

(ii) the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xiv) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and base

year contracted clinical hours for each provider [of]in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region; and

(iii) the applicable regional average facility reimbursement, which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the billed units for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region; and

(iv) the applicable regional average to/from transportation reimbursement which shall mean the quotient of the to/from transportation allocation for the base year divided by the provider billed units for the base year for each provider [of]in a DOH region, aggregated for all such providers in such region.

Such sum shall then be multiplied by the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvii) of paragraph (1) of this subdivision.

(3) Capital component.

(i) For Capital Assets Approved on or after July first, two thousand fourteen. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria for calculating provider reimbursement for the acquisition and lease of real property assets which require approval by the office for people with developmental disabilities. The regulations also address associated depreciation

and related financing expenses. The rate will include costs for actual straight line depreciation, interest expense, financing expenses, and lease cost.

In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset. The asset life for building acquisitions shall be twenty-five years.

[General principles. The rate shall include capital costs at the lower of the amount determined under 14 NYCRR Subpart 635-6 or thresholds as determined pursuant to subparagraph (iv) of this paragraph. The Department may retroactively adjust the capital component.]

[Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July first, two thousand fourteen.]

(ii) For Capital Assets Approved Prior to July first, two thousand fourteen. The State will identify each asset by provider, and provide a schedule of these assets identifying: total actual cost, reimbursable cost determined by the prior approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

In no case will the total reimbursable depreciation or principal amortization and total interest associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset.

(iii) Notification to Providers. 14 NYCRR Subpart 635-6 contains the criteria and standards associated with capital costs and reimbursement. Each provider will receive a schedule of approved reimbursable costs that is being used to establish the real property capital component of the provider's reimbursement rate.

(iv) Initial rate for capital assets approved on or after July first, two thousand fourteen. The rate shall include the approved appraised costs of an acquisition or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of the site, continuing until such time as actual costs are submitted to the State. [A provider shall be reimbursed for the lease or acquisition of property for approved appraised costs of such lease or acquisition with estimated costs for renovations, interest, soft costs and start-up expenses. Reimbursement for such estimated costs shall begin on the date of certification of such costs, continuing until such time as actual costs are submitted to the office for people with developmental disabilities. Reimbursement shall not exceed the regional threshold rates for such period. Such] Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the State [office for people with developmental disabilities] within two years from the date of site certification [of estimated costs, reimbursement for], the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

{v) Cost verified rates for capital assets approved on or after July first, two thousand fourteen. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the [office for people with developmental disabilities and] supporting documentation of such costs [shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department]. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the amount authorized in the approval process [threshold rates established in subparagraph (iv) of this paragraph]. Capital costs shall be depreciated [may be amortized] over a twenty-five[maximum fifteen] year period for acquisition of properties or the life of the lease for leased sites[, but in no circumstance shall the amortization exceed the length of the loan taken]. Capital improvements shall be depreciated over the life of the asset. The amortization of interest shall not exceed the life of the loan taken. Amortization or depreciation shall begin upon certification by the provider of such costs. Start-up costs may be amortized over a one year period beginning with site certification. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. [Limitations on reimbursement for such costs shall be the following:]

(vi) Capital reimbursement reconciliation schedule. Beginning with the cost reporting period ending December thirty-first, two thousand fourteen, each provider shall submit to OPWDD, as part of the annual cost report, a capital reimbursement reconciliation schedule.

This schedule will specifically identify the differences, by capital reimbursement item, between the amounts reported on the certified cost report, and the reimbursable items, including depreciation, interest and lease cost from the schedule of approved reimbursable capital costs.

The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital reimbursement reconciliation schedule.

The Department will retroactively adjust capital reimbursement based on the actual cost verification process as described in subparagraph (iv) of this paragraph.

[(*a*) Acquisition and rehabilitation costs. Cost is limited to the regional threshold of cost per square foot that includes acquisition costs and rehabilitation.]

[(*b*) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.]

[(*c*) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.]

[(*d*) Design fees. Design fees may not exceed five percent above the fee schedule.]

[(*e*) Equipment, furniture, supplies and miscellaneous. Based on the start-up allowance for day programs, and based on the threshold for day leased site.]

[(*f*) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate. Mortgages that do not amortize over the nominal mortgage term are not allowable.]

([*g*) Lease costs. Reimbursement is limited to the fair market rent and cannot exceed regional thresholds for renovations and per square foot rental threshold. For renovations in existing sites reimbursement is limited to one-half of the costs of the regional thresholds (Schedule A). Day sites which are leased are limited to those in which the renovation is not included in the lease as a "build out". This type of lease shall be limited to appraisal of the property specific to such lease]

[(*h*) Other costs. Maximum of $20,000. Other costs may include but not be limited to legal and accounting fees.]

[(*i*) Pre-operational rent. Reimbursement for rental costs prior to program certification is limited to three months in a day or residential leased site.]

[(*j*) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed $10,000.]

[(*k*) Purchase options. Limited to twelve months in length with a maximum of $15,000 in cost.]

[(*l*) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works, security, and bank site inspection.]

[(*m*) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than 12% of the mortgage amount. Site survey or soil inspection costs are not included]

[(*n*) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.]

[(iv) Thresholds. Threshold rates shall be determined pursuant to the following:]

[Capital Thresholds for Day Program Leased Space- New Space/Site.]

[*Threshold for Day Program Leased Space (Rentals)*]	
[County]	[Rental cost per square foot]
[Upstate (except where specified below)]	[$13.34 per square foot]
[Albany, Rensselaer, Saratoga, Schenectady, Sullivan, Orange, Rockland, Ulster, Dutchess, Putnam, Monroe, Onondaga, and Erie]	[$18.43 per square foot]
[Suffolk]	[$22.88 per square foot]
[Nassau and Westchester]	[$24.78 per square foot]
[New York City except Manhattan]	[$27.96 per square foot]
[Manhattan]	[$30.50 per square foot]

[Note: Capital Thresholds for Day Program Leased Space – New Space/Site. The threshold level is based on the cost per square foot and does not include heat, utilities or renovations. When heat

and utility costs are included in the lease and are required to be paid to the landlord, the contract costs for heat and utilities shall be paid to the provider in addition to such thresholds.]

[Day Program Leased Space Renovation Thresholds]

[New/Relocations]	[NYC , Westchester and Nassau]	[$8,100 x certified capacity]
	[All other counties	$6,100 x certified capacity]
[Expansion]	[NYC, Westchester and Nassau]	[$8,100 x increase in certified capacity]
	[All Other Counties]	[$6,100 x increase in certified capacity]

[Capital Thresholds for Day Program Acquisitions including Relocations]

[*Day Program Acquisition and Rehabilitation/New Construction Costs, Including relocations*]	
[Counties]	[Acquisition Thresholds]
[New York City]	[$187 per square foot]
[Monroe, Ulster, Dutchess, Rockland, Westchester, Nassau, Orange, Suffolk, and Sullivan]	[$161 per square foot]
[All other Counties]	[$136 per square foot]

[Day Program Renovation for existing sites]

[Counties]	[Acquisition Thresholds]
[New York City]	[$ 93.50 per square foot]
[Monroe, Ulster, Dutchess, Rockland, Westchester, Nassau, Orange, Suffolk and Sullivan]	[$ 80.50 per square foot]
[All other Counties]	[$ 68.00 per square foot]

[Capital Thresholds for Day Program Start-Up Costs]

[*Day Program Start-Up Allowance*]	
[Pre-Operational Rent]	[Up to 3 months (pre-operational)]
[Pre-Operational Utilities/Taxes]	[Up to 3 months, $10,000 maximum]
[Pre- Operational Staffing, including staff training]	[$350 x certified capacity]
[Pre- Operational Staffing FTEs, including staff training]	[4 FTEs, 6 weeks for admin, 2 weeks other staff]
[Pre- Operational Advertising]	[Included in "Pre-Operational Staffing"]

[Pre-Op Travel]	[Included in “Pre-Operational Staffing”]
[Pre- Operational Security Services]	[Included in “Miscellaneous”]
[Pre- Operational Furniture]	[Up to $500 x certified capacity]
[Pre- Operational Equipment/Supply]	[Up to $500 x certified capacity]
[Miscellaneous]	[Up to $5,000 per site]

[Design Fee]

[Approved Construction Costs]	[Design Fee	
[$0 to $15,000]	[$3,000]	[Subject to OPWDD approval]
[$15,001 to $50,000]	[$3,000]	[Plus 17.50% of cost over $15,000]
[$50,001 to $100,000]	[$9,125]	[Plus 15.50% of cost over $50,000]
[$100,001 to $150,000]	[$16,875]	[Plus 12.50% of cost over $100,000]
[$150,001 to	[$23,125]	[Plus 10.00% of cost over

$200,000]		$150,000]
[$200,001 to $250,000]	[$28,125]	[Plus 8.0% of cost over $200,000]
[$250,001 to $300,000]	[$32,125]	[Plus 4.75% of cost over $250,000]
[$300,001 to $350,000]	[$34,500]	[Plus 10.80% of cost over $300,000]
[$350,001 to $400,000]	[$39,900]	[Plus 10.60% of cost over $350,000]
[$400,001 to $450,000]	[$45,200]	[Plus 10.40% of cost over $400,000]
[$450,001 to $500,000]	[$50,400]	[Plus 10.20% of cost over $450,000]
[$500,001 to $550,000]	[$55,500]	[Plus 10% of cost over $500,000]
[$550,001 to $600,000]	[$60,500]	[Plus 9.80% of cost over $550,000]
[$600,001 to $650,000]	[$65,400]	[Plus 9.60% of cost over $600,000]
[$650,001 to $700,000]	[$70,200]	[Plus 9.40% of cost over $650,000]
[$700,001 to $750,000]	[$74,900]	[Plus 9.20% of cost over $700,000]

[$750,001 to $1,000,000]	[$79,500]	[Plus 10.20% of cost over $750,000]
[$1,000,001 to $1,500,000]	[$105,000]	[Plus 9.90% of cost over $1,000,000]
[$1,500,001 to $2,000,000]	[$154,500]	[Plus 9.90% of cost over $1,500,000]
[$2,000,001 to $2,500,000]	[$204,000]	[Plus 9.20% of cost over $2,000,000]
[$2,500,001 to $3,000,000]	[$250,000]	[Plus 7.60% of cost over $2,500,000]
[$3,000,001 to $3,500,000]	[$288,000]	[Plus 7.50% of cost over $3,000,000]
[$3,500,001 to $4,000,000]	[$325,500]	[Plus 6.90% of cost over $3,500,000]
[$4,000,001 to $4,500,000]	[$360,000]	[Plus 6.30% of cost over $4,000,000]
[$4,500,001 to $5,000,000]	[$391,500]	[Plus 5.70% of cost over $4,500,000]
[$5,000,001 to $5,500,000]	[$420,000]	[Plus 5.10% of cost over $5,000,000]
[$5,500,001 to $6,000,000]	[$445,500]	[Plus 4.50% of cost over $5,500,000]
[$6,000,001 to		[Plus 5.70% of cost over

$7,000,000]	[$468,000]	$6,000,000]
[$7,000,001 to $8,000,000]	[$525,000]	[Plus 3.50% of cost over $7,000,000]
[$8,000,001 to $9,000,000]	[$566,000]	[Plus 2.50% of cost over $8,000,000]
[$9,000,001 to $9,999,999]	[$585,000]	[Plus 1.50% of cost over $9,000,000]
[$10,000,000]	[To be negotiated]	

[Soft costs]

[*Soft costs*]
[Site survey $500 or $5,000 (new construction)]
[Builders risk insurance $2,000, or $4,000 (new construction)]
[Property casualty insurance $2,000]
[Bank site inspection $5,100 (new construction)]
[Performance Bond at 3% of the approved rehab costs over $99,999]
[Clerks of the works at an amount approved by OPWDD]
[Soil inspection at amount approved

by OPWDD]
[Security at amount approved by OPWDD]

86-10.4. Reporting requirements.

(a) Providers shall report costs and maintain financial and statistical records in accordance with 14 NYCRR Subpart 635-4.

(b) Generally Accepted Accounting Principles (GAAP). The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the provider unless the reporting instructions authorized specific variation in such principles. The State shall identify provider cost and providers shall submit cost data in accordance with generally accepted accounting principles (GAAP).

86-10.5. Trend Factor and Increases to Compensation.

(a) Trend Factor. For years in which the Department does not update the base year, subject to the approval of the Director of Budget, the Department may use a compounded trend factor to bring base year costs forward to the appropriate rate period. The trend factor shall be taken from applicable years from consumer and producer price indices, including, but not limited to the Medical Care Services Index; U.S. city average, by expenditure category and commodity and service group for the period April to April of each year.

(b) Increases to Compensation.

(1) Applicability. On or after January first, two thousand fifteen, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be effective January first, two thousand fifteen. The compensation increase funding will be included in the provider's rate issued for January first, two thousand fifteen or in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January first, two thousand fifteen. The compensation increase funding will be inclusive of associated fringe benefits.

(2) Definitions. As used in this section, the following terms shall have the following meanings:

(i) Direct support professionals are those defined as Direct Care and Support per Consolidated Fiscal Report (CFR) Appendix R and reported on the CFR under the Position Title code identifiers of 100 or 200. Contracted staff salary information will not be utilized.

(ii) Clinical staff are those defined as Clinical per CFR Appendix R and reported on the CFR under the Position Title code identifier of 300. Contracted staff salary information will not be utilized.

(iii) Eligible rate based programs shall mean supervised community residences (including supervised IRAs), supportive community residences (including supportive IRAs), or group day habilitation programs.

(3) Increases for Eligible Rate Based Programs.

(i) January first, two thousand fifteen Increase. Rates for eligible rate based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January first, two thousand fifteen. The compensation increase funding will be included in the provider's rate issued for January first, two thousand fifteen, or in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January first, two thousand fifteen. The compensation increase funding will be inclusive of associated fringe benefits.

(ii) April first, two thousand fifteen Increase. In addition to the compensation funding effective January first, two thousand fifteen, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April first, two thousand fifteen. The

compensation increase funding will be inclusive of associated fringe benefits. The April first, two thousand fifteen direct support professionals compensation funding will be the same, on an annualized basis, as that which was calculated for the January first, two thousand fifteen compensation increase and will be an augmentation to the January first, two thousand fifteen increase.

(iii) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July first, two thousand ten through June thirtieth, two thousand eleven for providers reporting on a fiscal year basis or January first, two thousand eleven through December thirty-first, two thousand eleven for providers reporting on a calendar year basis.

A) The January first, two thousand fifteen and April first, two thousand fifteen Direct Support Professionals compensation increase funding formula will be as follows:

1) The annual impact of a two percent increase to 2010-11 or 2011 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.

2) The annual impact of the two percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be

added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.

3) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.

4) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December thirty-first, two thousand fourteen, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

5) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December thirty-first, two thousand fourteen to calculate

the additional funding generated by the direct care compensation adjustment.

6) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January first, two thousand fifteen.

B) The April first, two thousand fifteen Clinical compensation increase funding formula will be as follows:

1) The annual impact of a two percent increase to 2010-11 or 2011 salaried clinical dollars and associated fringe benefits will be calculated.

2) The annual impact of the two percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.

3) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical

hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.

4) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December thirty-first, two thousand fourteen, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.

5) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December thirty-first, two thousand fourteen to calculate the additional funding generated by the clinical compensation adjustment.

6) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January first, two thousand fifteen.

86-10.6. Transition periods and reimbursement.

(a) Transition to new methodology. The reimbursement methodology described in this subpart will be phased-in over a three-year period, with a year for purposes of the transition

period meaning a twelve month period from July first to the following June thirtieth, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate according to the phase-in schedule immediately below. The base operating rate will remain fixed and the target rate, as determined by the reimbursement methodology in this subpart, will be updated to reflect rebasing of cost data, trend factors and other appropriate adjustments.

	Phase-in Percentage	
Transition Year	**Base operating rate**	**[New Methodology] <u>Target rate</u>**
Year One (July 1, 2014 – June 30, 2015)	75%	25%
Year Two (July 1, 2015 – June 30, 2016)	50%	50%
Year Three (July 1, 2016 - June 30, 2017)	25%	75%
Year Four (July 1, 2017 – June 30, 2018)	0%	100%

(b) Transition from monthly to daily units of service. Reimbursement for residential habilitation provided in supervised community residences shall be according to a daily unit of service. From the period beginning July first, two thousand fourteen through June thirtieth,

two thousand fifteen, providers that receive reimbursement of residential habilitation in supervised community residences pursuant to this Subpart shall determine and report to the Department retainer days, therapeutic leave days and vacant bed days.

(1) Retainer days shall mean days during which an individual is on medical leave from the community residence, or associated days when any other institutional or in-patient Medicaid payment is made for providing services to the individual. For the period beginning July first, two thousand fourteen through June thirtieth, two thousand fifteen, retainer days shall be reimbursed at zero dollars.

(2) Therapeutic leave days shall mean days during which an individual is away from the community residence and is not receiving services from residential habilitation staff, and the absence is for the purpose of visiting with family or friends, or a vacation. Therapeutic leave days shall be reimbursed at the level described in subdivision (a) of this section.

(3) Vacant bed days shall mean days for which the provider is unable to bill due to a resident moving from one residential site to another, or due to a resident passing away.

At the midpoint of the initial period and again at the conclusion of the period ending June thirtieth, two thousand fifteen, the Department will reconcile the services recorded under the retainer days in order to determine the amount of reimbursement owed to the provider. Providers shall be paid for retainer days at the level described in subdivision (a) of this section. Providers shall not be paid for more than fourteen retainer days per annual period for any one individual. Providers will be paid for vacant bed days at seventy five percent of the level described in subdivision (a) of this section, up to a maximum of ninety days per bed.

(c) For periods subsequent to June thirtieth, two thousand fifteen:

(1) The daily rate, as determined pursuant to this Subpart, excluding section 86-10.8, will be adjusted to include an occupancy factor.

(2) Retainer days shall be reimbursed at the daily rate as determined pursuant to subparagraph (1) of this paragraph. Such reimbursement shall be limited to fourteen days per individual.

(3) Therapeutic leave days shall be reimbursed per individual at the daily rate as determined pursuant to subparagraph (1) of this paragraph.

86-10.7. Rate corrections

(a) Arithmetic or calculation errors will be adjusted accordingly in instances that would result in a change of $5,000 or more in a provider's annual reimbursement for either residential habilitation services provided in community residences and/or day habilitation services.

(b) In order to request a rate correction in accordance with subdivision (a) of this section, the provider must send to the Department of Health its request by certified mail, return receipt requested, within ninety days of the provider receiving the rate computation or with ninety days of the first day of the rate period in question, whichever is later.

86-10.8. Specialized template populations. Notwithstanding any other provisions of this Subpart, rates for individuals identified by OPWDD as qualifying for specialized template populations funding shall be as follows. As used in this section, "Downstate" shall mean the counties of New York, Kings, Bronx, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange Sullivan, Putnam and Dutchess, and "Upstate" shall mean all other counties in New York State.[:]

(a) For individuals initially identified as qualifying for specialized template populations funding between November first, two thousand eleven and March thirty-first, two thousand fourteen

Residential – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$166,400
Upstate	$150,500

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$189,500
Upstate	$171,500

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual – Operating Only

Downstate	$136,500
Upstate	$123,500

Day Habilitation – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$41,730
Upstate	$37,562

Day Habilitation – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$46,433
Upstate	$43,063

(b) For individuals initially identified as qualifying for specialized template populations funding after March thirty-first, two thousand fourteen

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$189,500
Upstate	$171,500

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual – Operating Only
Downstate	$136,500
Upstate	$123,500

Day Habilitation – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual – Operating Only

Downstate	$46,433
Upstate	$43,063

(c) January first, two thousand fifteen Increase. The fees for specialized template populations funding will be revised to incorporate funding for compensation increases to direct support professional employees. Such fee increases will be effective January first, two thousand fifteen. The compensation increase funding will be included in the provider's fee issued for January first, two thousand fifteen or in a subsequent fee with the inclusion of funding in the amount necessary to achieve the same funding impact as if the fee had been issued on January first, two thousand fifteen. The compensation increase funding will be inclusive of associated fringe benefits.

(d) April first, two thousand fifteen Increase. In addition to compensation funding effective January first, two thousand fifteen, the fees for specialized template population funding will revised to incorporate funding for a compensation increase to direct support professional and clinical employees to be effective April first, two thousand fifteen. The April first, two thousand fifteen direct support compensation funding will be the same, on an annualized basis, as that which was calculated for the January first, two thousand fifteen compensation increase and will be an augmentation to the January first, two thousand fifteen increase.

(e) Calculations.

(1) The portion of the fee that is identified as direct care and support will be increased by 2% and multiplied by the fee sheet fringe benefit percentage to calculate the additional direct support compensation increases for January first, two thousand fifteen and April first, two thousand fifteen.

(2) The portion of the fee that is identified as clinical will be increased by 2% and multiplied by the fee sheet fringe benefit percentage to calculate the additional clinical compensation increase for April first, two thousand fifteen.

86-10.9. Severability. If any provision of this Subpart or its application to any person or circumstance is held to be invalid, the remainder of this Subpart and the application of that provision to other persons or circumstances will not be affected.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law (SSL) section 363-a and Public Health Law (PHL) section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program. In addition, Part I of chapter 60 of the laws of 2014, which is part of the 2014-15 enacted budget, requires the Department to provide funding beginning January 1, 2015 to

support a 2% increase in annual salary and salary-related fringe benefits for direct care staff, and also to provide funding beginning April 1, 2015 to support a 2% increase in annual salary and salary-related fringe benefits for direct care and clinical staff.

Legislative Objective:

These emergency/proposed regulations further the legislative objectives embodied in section 363-a of the Social Services Law and section 201(1)(v) of the Public Health Law and in Part I of chapter 60 of the laws of 2014. The emergency/proposed regulations amend the newly adopted methodology for reimbursement of residential habilitation delivered in Individualized Residential Alternatives (IRAs) and Community Residences (CRs) and day habilitation services.

Needs and Benefits:

On July 1, 2014, OPWDD and the Department of Health (DOH) implemented a new reimbursement methodology for residential habilitation in IRAs/CRs and day habilitation, which complements existing OPWDD requirements concerning these programs, to satisfy commitments included in OPWDD's transformation agreement with the federal Centers for Medicare and Medicaid Services (CMS).

After July 1, CMS informed OPWDD and DOH that the State could not use SSI benefits in excess of the room and board costs to offset the Medicaid rate for residential habilitation, and that CMS would require changes in reimbursement for capital assets used in day habilitation programs. These changes are that capital costs for day habilitation property acquisitions must be depreciated over 25 years and that providers must submit information for each capital asset that is verified by an independent auditor and identifies the differences, by asset, between the amounts reported on the cost report and the amounts that were prior approved by OPWDD. The emergency/proposed amendments are in response to these CMS requirements. The amendments

contain the methodology as described in the regulations adopted effective July 1, with changes to the SSI offset, day habilitation depreciation period and reporting for day habilitation capital costs, and with additional changes to the budget neutrality factor necessitated by the change in the SSI offset. In addition, the amendments contain provisions to reimburse IRA and CR providers for July 1 through November 1, 2014 for the difference between the November 1 rate and the July 1 rate, if the November 1 rate is higher. These amendments also make technical and clarifying changes to the regulations effective July 1, 2014.

These changes will increase reimbursement to providers, bring the methodology into compliance with current CMS policies regarding depreciation of capital assets and the treatment of individual benefits in HCBS waiver programs and provide information on capital costs required by CMS.

In addition, in recognition of the key role that direct support staff play in delivering services to persons with disabilities in New York State, the 2014-15 enacted budget included funding to support a 2% increase for direct support staff on January 1, 2015, and an additional 2% increase on April 1, 2015 for direct support staff, as well as a 2% increase for clinical staff beginning on April 1, 2015. OPWDD and the Department of Health (DOH) are revising the methodologies for affected residential and day habilitation programs to include funding to support these increases.

Costs:

Costs to the Agency and to the State and its local governments:

The emergency/proposed regulations will result in additional State share Medicaid costs of approximately $34 million per year. The regulations also require OPWDD or DOH to give each provider a schedule identifying (for each capital asset for which OPWDD approved the

costs prior to July 1, 2014) total actual costs, reimbursable costs, total financing cost, allowable depreciation and interest for the remaining useful life, and allowable reimbursement for each year of the remaining useful life.

The new methodology and the accompanying amendments do not apply to the state as a provider of services.

There will be no savings or costs to local governments as a result of these regulations because pursuant to Social Services Law sections 365 and 368-a, either local governments incur no costs for these services or the State reimburses local governments for their share of the cost of Medicaid funded programs and services. In addition, even if the amendments lead to an increase in Medicaid expenditures in a particular county, these amendments will not have any fiscal impact on local governments, as the contribution of local governments to Medicaid has been capped. Chapter 58 of the Laws of 2005 places a cap on the local share of Medicaid costs and local governments are already paying for Medicaid at the capped level.

Costs to private regulated parties:

The emergency/proposed regulations will amend the new reimbursement methodology for residential habilitation in IRAs/CRs and day habilitation. Application of the changes in the methodology for SSI and budget neutrality is expected to result in increased rates for all non-state operated providers. Overall reimbursement to providers will be increased by approximately $29 million from July 2014 through June 2015 due to this changes. Application of the changes in the methodology for capital cost to day habilitation may result in lower reimbursement per year, but full approved capital costs will be reimbursed over the 25 year amortization period.

Local Government Mandates:

There are no new requirements imposed by the rule on any county, city, town, village, school, fire or other special district.

Paperwork:

The emergency/proposed amendments increase paperwork to be completed by providers. The amendments require providers of day habilitation services to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. In addition for the 2% compensation increase, each provider will have to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees.

Duplication:

The emergency/proposed regulations do not duplicate any existing State or federal requirements that are applicable to services for persons with developmental disabilities.

Alternatives:

Since certain of the methodology changes in these amendments are required by CMS and others are mandated by State law, OPWDD and DOH did not consider any alternatives, because any alternatives would not be in compliance with recently articulated CMS policy and requirements.

Federal standards:

The emergency/proposed amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance schedule:

DOH is adopting the amendments on an emergency basis effective January 1, 2015. DOH expects to finalize the amendments as soon as possible within the timeframes established by the State Administrative Procedure Act.

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REGULATORY FLEXIBILITY ANALYSIS

FOR SMALL BUSINESS AND LOCAL GOVERNMENT

Effect of Rule:

OPWDD and DOH have determined, through a review of the certified cost reports, that most residential habilitation services delivered in Individualized Residential Alternatives (IRAs) and Community Residences (CRs) and most day habilitation services are provided by agencies that employ more than 100 people overall. However, some smaller agencies that employ fewer than 100 employees overall would be classified as small businesses. Currently, there are 348 providers of residential habilitation services delivered in IRAs and CRs and day habilitation services. OPWDD and DOH are unable to estimate the portion of these providers that may be considered to be small businesses.

The proposed regulations amend the rate-setting methodology that was adopted in July 2014 in conformance with changes mandated by CMS after July 1, 2014.

After July 1, 2014, CMS informed OPWDD and DOH that the State could not use SSI benefits in excess of the room and board costs to offset the Medicaid rate for residential habilitation, and that CMS would require changes in reimbursement for capital assets used in day habilitation programs. These changes are that capital costs for day habilitation property acquisitions must be depreciated over 25 years; that providers must submit a schedule that identifies the differences, by capital asset, between the amounts reported on the cost report and the amounts that were approved by OPWDD; and that an independent auditor apply procedures to verify the accuracy and completeness of the schedule. The amendments contain the methodology as described in the regulations adopted in July 2014, with changes to the SSI offset,

day habilitation depreciation period and reporting for day habilitation capital costs, and with additional changes to the budget neutrality factor necessitated by the change in the SSI offset. Application of the changes in the methodology regarding SSI offsets and budget neutrality is expected to result in increased rates for all providers, including providers that are small businesses. Overall reimbursement to providers will be increased by approximately $29 million for July 2014 through June 2015. Application of the changes in the methodology for capital costs to day habilitation may result in lower reimbursement per year, but full approved capital costs will be reimbursed over the 25 year amortization period.

The changes also include an amendment to reimburse IRA and CR providers, including providers that are small businesses, for the difference between the November 1 rate and the July 1 rate, if the November 1 rate is higher. These regulations also make technical and clarifying changes to the regulations effective July 1, 2014.

In addition, the 2014-15 enacted budget included funding to support a 2% increase for direct support staff on January 1, 2015 and April 1, 2015, as well as a 2% increase for clinical staff on April 1, 2015 for eligible programs. This change to the methodology will increase rates for all providers of the eligible services.

Compliance Requirements:

The amendments require providers of day habilitation services to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. In addition, for the 2% compensation increase, each provider will be required to

submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees.

Professional Services:

Additional professional services will be required as a result of these regulations. The amendments require providers of day habilitation services to verify the accuracy and completeness of the capital assets schedule. However, the regulations will not add to the professional service needs of local governments.

Compliance Costs:

The amendments require providers of day habilitation services to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. In addition, for the 2% compensation increase, each provider will be required to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees.

Economic and Technological Feasibility:

The amendments do not impose on regulated parties the use of any technological processes.

Minimizing Adverse Impact:

Since the certain of the methodology changes in these amendments are required by CMS, OPWDD and DOH did not consider any alternatives, because any alternatives would not be in compliance with recently articulated CMS policy and requirements. The potential loss of federal funds that could result from non-compliance would have had far more serious consequences to

providers than the minor decrease in yearly reimbursement for day habilitation costs that may result from these changes.

For the 2% compensation increase, there is no adverse economic impact on providers. Each provider will need to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees. However, the attestation is required by the enacted budget and is needed to ensure that the compensation increases are used for their intended purpose.

The Department has also reviewed and considered the approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act. The Department determined that the revision to reimbursement proposed in this amendment is the most optimal approach to instituting the necessary change in rate methodology while minimizing any adverse impact on providers.

Small Business and Local Government Participation:

OPWDD and DOH met with representatives of providers to discuss the SSI offset changes in the new methodology (including provider concerns) on July 21, August 18, and September 15. OPWDD and DOH also met with representatives of providers to discuss the capital changes on October 6, 2014, and met with them to discuss the 2% compensation increase on December 15. The New York State Association of Community and Residential Agencies (NYSACRA), which represents some providers that have fewer than 100 employees, was included in these meetings.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Description of the types and estimation of the number of rural areas in which the rule will apply: OPWDD services are provided in every county in New York State. 43 counties have a population of less than 200,000: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates. Additionally, certain townships in 10 counties have a population density of 150 persons or less per square mile: Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga, Orange and Saratoga.

The proposed regulations amend the rate-setting methodology that was adopted in July 2014 in conformance with changes mandated by CMS after July 1, 2014.

After July 1, 2014, CMS informed OPWDD and DOH that the State could not use SSI benefits in excess of the room and board costs to offset the Medicaid rate for residential habilitation, and that CMS would require changes in reimbursement for capital assets used in day habilitation programs. These changes are that capital costs for day habilitation property acquisitions must be depreciated over 25 years; that providers must submit a schedule that identifies the differences, by capital asset, between the amounts reported on the cost report and amounts that were approved by OPWDD; and that an independent auditor apply procedures to verify the accuracy and completeness of the schedule. The amendments contain the

methodology as described in the regulations adopted in July 2014, with changes to the SSI offset, day habilitation depreciation period and reporting for day habilitation capital costs, and with additional changes to the budget neutrality factor necessitated by the change in the SSI offset. Application of the changes in the methodology regarding SSI offsets and budget neutrality is expected to result in increased rates for all providers, including providers in rural areas. Overall reimbursement to providers will be increased by approximately $29 million for July 2014 through June 2015. Application of the changes in the methodology for capital costs to day habilitation may result in lower reimbursement per year, but full approved capital costs will be reimbursed over the 25 year depreciation period.

The changes also include an amendment to reimburse IRA and CR providers, including providers in rural areas, for the difference between the November 1 rate and the July 1 rate, if the November 1 rate is higher. These regulations also make technical and clarifying changes to the regulations effective July 1, 2014.

In addition, the 2014-15 enacted budget included funding to support a 2% increase for direct support staff on January 1, 2015 and April 1, 2015, as well as a 2% increase for clinical staff on April 1, 2015 for eligible programs. This change to the methodology will increase rates for all providers of the eligible services.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

There will be additional reporting, recordkeeping, and professional services imposed by these amendments. The amendments require providers of day habilitation services to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences,

by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. In addition, for the 2% compensation increase, each provider will be required to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees.

The amendments will have no effect on local governments.

No additional professional services will be required as a result of these regulations and the regulations will not add to the professional service needs of local governments.

Costs:

The amendments require providers of day habilitation services to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. In addition, for the 2% compensation increase, each provider will be required to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees.

Minimizing Adverse Impact:

Since certain of the methodology changes in these amendments are required by CMS, OPWDD and DOH did not consider any alternatives, because any alternatives would not be in compliance with recently articulated CMS policy and requirements. The potential loss of federal funds that could result from non-compliance would have had far more serious consequences to providers than the minor decrease in annual reimbursement for day habilitation capital costs that may result from these changes.

For the 2% compensation increase, there is no adverse economic impact on providers. Each provider will need to submit an attestation, signed by members of the board of directors, stating how the provider will distribute the direct care and clinical compensation payments to its employees. However, the attestation is required by the enacted budget and is needed to ensure that the compensation increases are used for their intended purpose.

The Department has also reviewed and considered the approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act. The Department determined that the revision to reimbursement proposed in this amendment is the most optimal approach to instituting the necessary change in rate methodology while minimizing any adverse impact on providers.

Rural Area Participation:

Participation of public and private interests in rural areas: OPWDD and DOH met with representatives of providers to discuss the SSI offset changes in the new methodology (including provider concerns) on July 21, August 18, and September 15. OPWDD and DOH met with representatives of providers to discuss the capital changes on October 6, 2014, and met with them to discuss the 2% compensation increase on December 15, 2014. The NYS Association of Community and Residential Agencies (NYSACRA), which represents some providers in rural areas, was included in these meetings.

JOB IMPACT STATEMENT

A job impact statement is not being submitted for this emergency/proposed rulemaking because this rulemaking will not have a substantial adverse impact on jobs or employment opportunities.

The emergency/proposed regulations amend the rate-setting methodology that was adopted in July 2014 in conformance with changes mandated by CMS after July 1, 2014. In addition, the proposed regulations change the methodologies for rates and fees for the affected programs to provide funding to support a January 1, 2015 2% salary increase and an April 1, 2015 2% increase for direct support staff, as well as an April 1, 2015 2% increase for clinical staff for the affected residential and day programs, to include funding to support these increases.

All providers will experience an increase in funding as a result of the changes to the SSI offset, budget neutrality factor and 2% compensation increase in these amendments. Application of the changes in the methodology for capital costs to day habilitation may result in lower reimbursement per year, but full approved capital costs will be reimbursed over the 25 year depreciation period.

The amendments are therefore expected to have no significant adverse impact on jobs and employment opportunities with providers.