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Private Nonmedical Institution Provider Manual

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Section 1 Introduction

This manual supplements existing federal and state law, primarily including the Division of Rate Setting's *Methods, Standards and Principles for Establishing Payment Rates for Private Nonmedical Institutions Providing Residential Child Care Services* (V.P.N.M.I.). This manual applies Medicaid-enrolled providers of residential childcare services licensed by the Department of Children and Families or the Department of Mental Health that receive per diem rates from the Division under the V.P.N.M.I.

This manual describes the main aspects of the rate-setting process, including general administrative requirements (Section 2), requirements for filing funding applications (Section 3), how the Division determines which costs are allowable (Section 4), how the Division allocates costs (Section 5), caps, limits, and inflation increases on PNMI rates (Section 6), and how the Division calculates a final PNMI rate (Section 7).

Section 2 General Provisions

2.1 Representation in DRS Matters

Private nonmedical institutions are a diverse group of nonprofits, local authorities, and for-profit corporations of various size and complexity, most of whom offer private nonmedical institution services in addition to a wide array of other services. It can be challenging to know who at each provider needs or desires to receive notices of decisions that affect the provider. Accordingly, V.P.N.M.I.R. § 1.11 requires providers to notify the Division of all personnel who shall receive notices of Division decisions.

Providers may identify both general and special representatives to receive notices. A general representative is an individual who shall receive notice of all Division decisions with respect to that provider. A special representative is an individual who shall receive notice of all Division decisions with respect to one matter, such as an appeal of an adjustment or a request for a rate adjustment.

Providers may select more than one representative of either type. Providers may select only nursing home administrators, licensed attorneys, or certified public accountants as their representatives, and may not be represented by laypeople or clinicians.

Providers must use forms the Division has created to identify general and special representatives. To download copies of the forms, visit the Division's website. The forms may include additional requirements, such as listing a representative's address and title and requiring the representative to affirm that they have the authority to receive notifications from the Division.

When a provider names a representative, the representative must select if they wish to be served documents by mail, fax, or email. If a provider chooses to be served documents by fax or email, they consent to the risks of electronic communications, including the risk that an email may be unsent because of file size limitations.

If a provider has multiple representatives that share a physical address and request notice by mail, the Division shall not send duplicate copies of documents to that physical address.

2.2 Procurement Standards

Providers must establish and maintain a code of standards to assess the performance of employees who procure goods and services. The standards must provide, to the extent practicable, that the provider values open and free competition among multiple vendors. Providers should participate in group purchasing plans where feasible.

If a provider pays more than what the Division determines to be a competitive bid for a good or service, any amount over a lower bid that cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle will not be an allowable cost under the Division's rules or this manual.

2.3 Cost Allocation Plans and Changes in Accounting Principles

2.3.1 In General

a. Any cost allocated to the private nonmedical institution must be a reasonable cost.

b. The preferred statistical methods for allocating specific costs are as follows:

   (1) Salaries and wages: Direct costs, identifying and dividing the time spent working for the private nonmedical institution and time spent working for any other program operated by the provider.

(2) Employee benefits: Direct costs, identifying and dividing the time spent working for the private nonmedical institution and time spent working for any other program operated by the provider. The portion of benefits fairly allocable to the private nonmedical institution may be allocated there. Alternatively, a provider may allocate a portion of all employee benefits to the private nonmedical institution equivalent to the ratio of (A) gross salary and wages for the private nonmedical institution to (B) gross salary and wages for the entire provider.

(3) Facility costs, costs of operation, and maintenance: square footage of private nonmedical institution to total square footage of program. Facilities must provide a floor plan and square footage calculation to support their allocation. Alternatively, providers may allocate costs by agreement with the Division.

(4) Food and laundry: ratio of private nonmedical institution residents to total residents.

2.3.2 Recognizing Changes in Accounting Principles

The Division reserves the right not to recognize a change in accounting principles, methods, or bases of cost allocation if the Division finds that the change was intended to, or likely will, increase the provider's Medicaid payments.

Section 3 Funding Applications

The Division's rules, V.P.N.M.I. § 3, require providers to file annual statistical and financial information in the form of a funding application. The funding application is the basis for all of the work done by the Division in setting a facility's rate.

The funding application template is available on the Division's website. Providers must file funding applications using this template. If a provider fails to file a funding application using this template, the Division shall reject the funding application. Funding applications must be signed by the facility's owner or by the owner's authorized representative.

In addition to the template, providers must also submit audited financial statements, including sub-schedules showing total PNMI revenues and costs, including allocated costs, and showing PNMI program net revenue. If a provider fails to file this supporting documentation, the Division shall reject the funding application.

The Division may also request other data, statistics, or information as necessary to carry out its functions, as prescribed in Section 3.2(e) of the Division's PNMI rules. If the Division requests other information while reviewing a provider's funding application, but the provider fails to submit the requested information, the requested information shall not be admissible at any other stage of the rate setting process, including any subsequent appeal of a final decision of the Division.

3.1 Deadlines for Filing a Funding Application

All providers must file a funding application at least annually for the 12-month period that covers the provider's fiscal year. The Division may also request that a provider file a special funding application or a budget funding application covering a shorter or greater period of time. Providers must file an acceptable annual funding application according to the deadlines prescribed in Section 3.3(a) of the Division's rules.

3.2 Extensions of Time

The Division may grant an extension to a provider who is unable to file an acceptable funding application according to the Section 3.3(a) deadline. The Division may grant an extension to a provider who is unable to complete time studies as provided for under Section 1.8(g) of the Division's PNMI Rules.

To receive an extension, providers must file a request in writing on a form prescribed by the Division. Forms are available on the Division's website. The Division must receive the request before the deadline specified in Section 3.3(a). The request must clearly state the reason that the provider is requesting an extension and the date on which the Division will receive the funding application. If a request for an extension fails to meet these criteria, the Division shall reject the request for an extension.

The Division shall grant an extension only for good cause. Under this manual, "good cause" means a substantial reason that affords a legal excuse for a delay, an intervening action beyond the provider's control, or both. For example, the Division may find good cause exists for delay if a natural disaster prevents the funding application preparer from reporting to work in person or electronically, or a ransomware attack prevents the provider from accessing its records. The Division shall not find that good cause exists for extending a funding application deadline if the reason for the delay is ignorance of the rule, the inconvenience of preparing a funding application, or because the person who typically prepares the funding application is busy with other work.

Section 4 Allowable Costs

After receiving a funding application, the Division shall determine the allowability and reasonableness of the costs a provider reports as described in V.P.N.M.I.R. Section 4.1. In general, if the Division's rules, this manual, or CMS's Medicare Provider Reimbursement Manual (CMS-15) do not address whether a cost is allowable, the Division shall review the cost in accordance with Generally Acceptable Accounting Practices (GAAP).

This manual addresses specific categories of costs and addresses whether they are allowable or unallowable.

4.1 Non-Recurring Costs

Any reasonable, resident-related non-capital cost that would increase the provider's approved costs by two percent or more that is not expected to recur at least annually is a non-recurring cost. Providers shall capitalize and amortize these costs for a period of three years.

4.2 Property and Related Costs

Certain costs shall be reimbursed as property and related costs, including:

a. Depreciation on buildings and fixed equipment, motor vehicles, land improvements, and amortization of leasehold improvements and capital leases.
b. Interest on capital indebtedness.
c. Real estate leases and rents.
d. Real estate or property taxes, or payments in lieu of property taxes, provided that they are the provider's legal obligations and do not exceed the amount of property taxes that the provider would have paid if the property were subject to regular property taxation.
e. Equipment rental.
f. Fire and casualty insurance.
g. Amortization of mortgage acquisition costs and non-recurring costs under Section 4.1 of this Manual.
h. Repairs and maintenance.

4.3 Interest Expense

V.P.N.M.I.R. Section 4.6(a) requires the Division to allow interest expenses that are necessary and proper.

4.3.1 Necessary Interest

Interest shall only be treated as "necessary" under the Division's rules when interest is incurred on a loan to satisfy a provider's financial need and the provider had a legal obligation to pay the interest.

Any interest or other financial obligations incurred as a result of an interest rate swap or other similar transactions are necessary costs only when the interest or other financial obligations were incurred to satisfy a provider's financial need.

4.3.2 Proper Interest

Interest expense shall only be treated as "proper" under the Division's rules when providers incur the interest at a rate not in excess what a prudent buyer would have had to pay in the money market existing at the time the loan was made.

Interest paid as part of a transaction with a related party or parties is not proper interest, unless:

- The interest expense relates to a first or second mortgage, or to assets leased from a related party where the costs to the related party are recognized in lieu of rent, and
- The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

Interest paid with respect to a capital expenditure in property, plant, or equipment that is related to resident care that requires approval from any governmental body, and for which the necessary approval was not granted, is not proper interest.

Interest on loans that do not include reasonable and ordinary principal repayments in the debt service payments is not proper interest, except to the extent that it would have been incurred pursuant to a standard amortization schedule for a term equivalent to the useful life of the asset.

4.3.3 Offset

Interest expenses shall be reduced by realized investment income, except where that income is from funded depreciation that has been recognized by the Division under its rules or this manual, or where that income is from any grants or gifts. If the provider incurs interest expenses from working capital, the Division shall only offset these expenses using interest income derived from working capital.

4.3.4 Refinancing

When refinancing debts, a provider must demonstrate that the costs of refinancing – including account fees, legal fees, and new debt acquisition costs – must be less than the allowable costs of the provider's current financing.

If the principal balance of a refinanced debt exceeds the principal balance of the previous debt plus accounting fees, legal fees, and debt acquisition costs, the Division shall consider the refinanced debt a working capital loan and must determine whether the loan is necessary under Section 4.3.1 of this manual.

To the extent that a refinanced loan's principal includes material interest expense related to the original loan's unpaid interest charges, the refinanced loan's principal shall not be allowed.

4.4 Determining the Basis of Property, Plant, and Equipment

The basis of a donated asset is the fair market value of the asset. For all other assets that a provider owns and uses in providing resident care, the basis of the asset is the lower of either the cost of the asset or the fair market value of the asset, unless another provision of this manual or the Division's rules specifies a different method for determining an asset's basis.

An asset's cost, under this section, includes the asset's purchase price, any applicable sales tax, and any costs to prepare the asset for its intended use, including but not limited to shipping, handling, installation, consulting, legal fees, and architectural fees.

4.4.1 Basis of Betterments and Improvements

Providers may improve or better an asset. If an improvement or betterment extends the useful life of an asset two or more years, or significantly increases the productivity of an asset, the basis of the betterment or improvement shall be the costs of the improvement or betterment as if it was a new construction.

4.4.2 Assets with Significant Basis and Useful Life

Providers must capitalize and depreciate any asset with a basis of $10,000 or more and a useful life of two or more years in accordance with Section 4.4 of this manual. Providers must also capitalize

and depreciate any groups of assets if the majority of the assets in the group have a basis of $2,000 or more and a useful life of two or more years in accordance with Section 4.4 of this manual. Providers may choose to capitalize and depreciate any other assets if doing so would be reasonable.

4.5 Requirement to Capitalize and Depreciate or Amortize Assets

Providers must compute depreciation and amortization on the straight-line method.

In general, the Division estimates the useful life of an asset by referring to the most recent version of the Estimated Useful Lives of Depreciable Hospital Assets published by the American Hospital Association. If a provider has negotiated an arms-length lease of an asset, leasehold improvements may be amortized over the term of the lease if the term of the lease is shorter than the estimated useful life of the asset. The term of the lease includes any renewal period specifically stated in the lease.

4.6 Leasing Arrangement for Property, Plant, and Equipment

In general, providers may not use rental or leasing arrangements to inflate their allowable costs above what their costs would have been had they purchased the same services at market price.

If a provider leases facilities or equipment from a related organization, the provider's rent expense shall be limited to Medicaid allowable interest, depreciation, insurance, and taxes incurred for the year under review, or the price of comparable services or facilities purchased or leased elsewhere, whichever is lower.

Rent or lease charges, including sale and leaseback agreements for property, plant, and equipment that would otherwise be allowable, cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance, and depreciation.

4.7 Depreciation Funding

In general, to incentivize providers to use depreciation funding to conserve assets, the Division shall not reduce allowable interest expense if a provider reports investment income on funded depreciation.

Providers must maintain appropriate documentation to support the funded depreciation account and income earned on the account to be eligible for this relief. If a provider deposits funds in a funded depreciation account without retaining sufficient working capital or resources to support ongoing operations, the Division shall not recognize the deposits as funded depreciation.

If a provider uses funded depreciation for any purpose other than acquiring or replacing a facility asset without Division approval, the Division shall offset investment income on funded depreciation for all future funding applications until the amount is recouped. Vermont Medicaid further may be required to recover the amount from past or future payments.

4.8 Advertising Expenses

Reasonable and necessary expenses for advertisements to secure necessary employees is an allowable cost. Providers may purchase advertisements in newspapers or other media circulated to the public for this purpose. All other advertisement and public relations costs are not allowable.

For the Division to accurately review and allow costs under this section, providers must accumulate all day care costs in a separate cost center. Providers must identify revenues for providing day care for employees and non-employees in separate accounts.

4.9 Legal Costs

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

4.10 Litigation and Settlement Costs

All costs allowed under this section are non-recurring costs within the meaning of this manual.

In general, the Division will recognize attorneys' fees and other expenses incurred for litigation only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance. If a provider settles a matter before a jury or bench verdict (whether or not a lawsuit has been filed), the Division will recognize one-half of the costs, including attorneys' fees, settlement award, and other expenses to the extent that the costs are related to resident care and not covered by insurance.

Litigation and settlement costs incurred in response to criminal investigations and professional licensing matters are not related to resident care for the purposes of this section and are not allowable costs.

If a provider incurs attorneys' fees and other similar expenses when challenging a decision of the Division, the Division shall allow the costs to the extent that the provider prevails, as determined by a ratio of total dollars at issue in the case to the total dollars the provider is awarded.

4.11 Related Party Expenses

If a provider pays otherwise allowable expenses to a related party, the Division shall disallow the costs, subject to the following exception. The Division may allow the costs if the provider identifies all related party expenses, the relationship the provider has with the related party, and all expenses attributable to the related party. The provider must also demonstrate that the related party expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies that the provider could purchase elsewhere.

4.12 Revenues

If a facility reports operating or non-operating revenues related to goods or services they provide, the costs to which those revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than the costs to which the revenues correspond, the deduction shall be equal to such costs.

4.13 Travel/Entertainment Costs

Reasonable and necessary costs of meals, lodging, transportation, and incidentals incurred for purposes related to resident care are allowable. All costs that the Division determines are for the pleasure and convenience of the provider or the providers' representatives will not be allowed.

4.14 Transportation Costs

Reasonable and necessary costs for transportation, other than ambulance services for emergency transportation or for transportation home from a nursing facility, that are related to the care of residents are allowable. Transportation costs shall include the depreciation of utility vehicles, mileage reimbursement to employees when employees use their privately owned vehicles to transport residents, and any contractual arrangements for providing transportation. Transportation costs shall not be separately billed for individual residents.

4.15 Compensation Limitations

The Division shall disallow any reported salary, including indirect or allocated salary, that is more than seven times the lowest paid direct care non-allocated PNMI staff person's hourly compensation. This section shall not apply to the salaries or fees paid to licensed professionals providing direct care to residents.

4.16 Costs for New Programs

If a provider wishes to propose a new PNMI program, they may submit a proposal including a budget cost report to the Division. The Division shall report on the proposal to the PADs. The PADs shall approve or deny reimbursement for a new program. The PADs may further authorize reimbursement for pre-opening start-up costs for new programs.

If the PADs approve reimbursement for a new program, the Division shall set a per diem rate on the basis of the budget cost report for the program. The Division may periodically review and revise the budgeted startup costs and rate for a program based on its actual costs.

If a program wishes to be reimbursed for pre-opening start-up costs, it should apply for such reimbursement before incurring those expenses. Eligible costs may include, but are not limited to, capital expenditures, supplies, staffing, and training costs. The PADs may choose to reimburse these costs by lump sum or by building these costs into the program's approved budget for its first year of operation.

A program may undergo significant program changes such that it is, in effect, beginning a new program. Under these circumstances, a budget rate may be preferable for both the program and the Division to ensure that the program's rate is justified by its circumstances. To receive a budget rate under these circumstances, the program must apply for budget reimbursement before incurring any expenses as required by this section. The PADs may choose to reimburse program costs as provided in this section.

Section 5 Cost Classification

After the Division determines a cost is allowable, the cost is assigned to a service category. There are three service categories that are directly related to providing care to residents. A fourth category, administration, relates to program administration. All allowable program costs are allocated to one of these four categories. To determine total allowable program costs, the administrative category is re-allocated to the three service categories. The Division's rules, V.P.N.M.I.R. § 5, describes the different categories and their related costs.

Section 6 Reimbursement Standards

6.1 Minimum Occupancy Level

The Division, in consultation with the PADs, shall set a minimum occupancy level for each program to use in calculating the per diem rate for each program. The Division may exempt a program from its required minimum occupancy level when granting extraordinary financial relief under V.P.N.M.I.R. § 9.

6.2 Cap on Increases from Prior Base Year to Current Base Year

The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to this section.

a. For programs with rates calculated pursuant to subsection 7.1, the Division shall calculate a cap for each program's per diem rate as follows:

(1) If the Division recaptured net PNMI revenue under subsection 7.3, the Division will add that recaptured revenue back to the uninflated prior base year per diem rate for the purposes of this section.

(2) The Division shall determine an uninflated occupancy adjusted per diem rate. This uninflated occupancy adjusted per diem rate will compensate for the increase in the per diem rate that occurs when a lower number of resident days is used in the rate calculation. In calculating the uninflated occupancy adjusted per diem rate, the Division will use the resident days from the prior base year rate calculations. The uninflated occupancy adjusted per diem rate will be calculated as follows:

i. If the current base year resident days are equal to or greater than the prior base year resident days, the Division shall multiply the uninflated prior year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100%. The result will be the uninflated occupancy adjusted per diem rate.

ii. If the current base year resident days have decreased from the prior base year resident days that were used in the rate calculation but are still above the program's minimum allowed occupancy established pursuant to subsection 6.1 of this Manual, the current base year actual days will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the uninflated prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100% plus the percentage decrease in resident days from the prior base year to the current base year. The result will be the uninflated occupancy adjusted per diem rate.

iii. If the current base year resident days have decreased from the prior base year resident days that were used in the rate calculation but are now below the program's minimum allowed occupancy established pursuant to subsection 6.1 of this Manual, the program's minimum allowed occupancy will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the uninflated prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding any rate adjustments, by 100% plus the percentage decrease in the resident days from the prior base year. The result will be the uninflated occupancy adjusted per diem rate.

(3) *Allowed Percentage Increase to the Uninflated Occupancy Adjusted Per Diem Rate.* The table below shows the factor to be applied to the uninflated occupancy adjusted prior base year per diem rate to calculate the cap on the current year uninflated per diem rate in accordance with paragraph (a)(4). This factor is on a scale that relates to the magnitude of the programs' prior base year allowable costs before revenue offset.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to $600,000	9.00%
$600,000 - $1,000,000	8.00%
$1,000,001 - $1,800,000	7.00%
$1,800,001 - $4,000,000	6.00%
Over $4,000,000	5.00%

(4) The cap on the current year uninflated per diem rate, excluding rate adjustments, is the uninflated occupancy adjusted prior base year per diem rate calculated pursuant to paragraph (a)(2), multiplied by 100% plus the factor from the table in paragraph (a)(3). The result will be the maximum uninflated per diem rate the provider may receive for the current base year. If the uninflated calculated per diem rate exceeds the maximum uninflated allowed per diem rate, the difference will be the uninflated per diem effect of the cap. The uninflated per diem effect of the cap shall be adjusted by the annual inflation factor pursuant to subsection 6.3 of this Manual, and the resulting inflated per diem effect of the cap shall be subtracted from the inflated calculated per diem rate to arrive at the capped per diem rate. Existing and new rate adjustments will be added to the capped per diem rate for the total allowed per diem rate.

b. For crisis/stabilization programs with rates calculated pursuant to subsection 7.2, the Division shall cap cost increases from year to year as follows:

(1) The Division will add back to the prior base year allowable costs any revenue offset amounts made for the recapture of net PNMI revenue in excess of five percent pursuant to subsection 7.3. This will be the allowable costs for the year-to-year comparison.

(2) The prior base year allowable costs, calculated pursuant to paragraph (b)(1), multiplied by 100% plus the factor from the table below will be the cap on annual costs used for reimbursement for the current base year. The annual inflation factor will be applied to the remaining base year allowable costs after the cap has been applied. Existing and new rate adjustments amounts will be added to this cap to determine the maximum allowed costs.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to $600,000	9.00%
$600,000 - $1,000,000	8.00%
$1,000,001 - $1,800,000	7.00%
$1,800,001 - $4,000,000	6.00%
Over $4,000,000	5.00%

c. An exemption from the cap calculated pursuant to paragraphs (a) and (b), may be available at the discretion of the PADs in the following instances:

(1) for an existing program that is converted to a PNMI, until the second full year that the program's base year actual annual costs from operating as a PNMI are used for rate setting.

(2) for a new PNMI start-up program or significantly changed PNMI program, pursuant to subsection 4.16 of this Manual, until the second full base year where actual annual costs are used for rate setting.

6.3 Inflation

a. The Division shall calculate a single annual inflation factor for each program's fiscal year end. The Division shall adjust each PNMI program's allowable costs used in each PNMI program's rate calculation according to this annual inflation factor. The Division shall adjust for inflation after the effect of any caps or limits have been resolved to ensure that the inflation adjustment is not also capped.

b. To calculate the annual inflation factor, the Division shall review the costs incurred in the most recent complete set of base year data submitted by each PNMI program. The Division shall assign each cost to one of three cost subcomponent categories: (1) Total Salary and Contract Costs; (2) Employee Benefits; and (3) Other Costs.

c. The Division shall calculate a subcomponent inflation factor for each subcomponent category. The Division shall calculate the annual inflation factor as a weighted average of the inflation factors for each subcomponent inflation factor. For example, if the total Vermont PNMI costs were comprised of 58.5% Total Salary and Contract Costs, 16.4% Employee Benefits, and 25.1% Other Costs, the weight for the Total Salary and Contract Costs inflation factor would be 0.585, the weight for the Employee Benefits inflation factor would be 0.164 and the weight for the Other Costs inflation factor would be 0.251.

d. The Division shall use the most recent publication of the Health Care Cost Service available on January 1 prior to the July 1 start of the rate year to calculate the annual inflation factor.

(1) The Total Salary and Contract Cost inflation factor shall be calculated using the wages and salaries price index of the Health Care Cost Nursing Home Market Basket.

(2) The Employee Benefits inflation factor shall be calculated using the employee benefits price index of the Health Care Cost Nursing Home Market Basket.

(3) The Other Costs inflation factor shall be calculated using the New England consumer price index.

Section 7 Calculating Costs, Limits, and Rates

This section describes how the Division calculates final per diem rates using the elements described previously in this Manual and the Division's PNMI rules.

7.1 Calculating the Per Diem Rate

Using each program's settled base year funding application, the Division shall calculate a per diem rate by dividing total allowable base year costs by total base year resident days, subject to any applicable minimum occupancy requirements.

The Division shall limit the current rate period's per diem rate by the cap calculated pursuant to Section 6.2 of this Manual and adjust each program's allowable costs by applying an inflation factor pursuant to Section 6.3 of this Manual.

The Division shall then add any existing or new rate adjustments granted under its rules and this Manual to arrive at the total allowed per diem rate.

The Division shall then develop a per diem rate for each of the service categories set out in section 5.3 of the Division's PNMI rules and Section 5 of this Manual.

7.2 Calculating the Per Diem Rate for Crisis/Stabilization Programs

The Division shall set rates for crisis/stabilization programs retroactively.

The Division shall use each program's settled base year funding application as the basis for setting a rate. The Division shall calculate monthly total allowable costs by dividing the total allowable costs by 12.

Within five days of the end of each month, the program shall submit the prior month's census to the Division. The Division shall calculate a per diem rate by dividing the monthly total allowable costs by the total number of resident days for the month that just ended.

The Division shall limit increases from year to year in total allowable base year costs for crisis/stabilization programs by calculating a cap under Section 6.2 of this Manual. The Division shall add any existing or new rate adjustments granted under its rules and this Manual to arrive at the total allowed per diem rate.

7.3 Recapturing Net PNMI Revenue

In general, when reviewing a program's audited financial statements as part of the funding application, the Division will recapture PNMI profit by applying net revenue in excess of five percent against the current year's total allowable costs.

The Division will not recapture net revenue when it is attributable to a state or federal grant directly related to the program's PNMI services.

If a program anticipates that it will generate profit that may be recaptured under this section, it can notify the Division about the anticipated profit and request to retain the anticipated profit to use to invest in the program's services or facilities prior to submitting a funding application for the subsequent fiscal year. The program must describe how it will reinvest the anticipated profit. If the Division, in consultation with the PADs, approves the program's plan, the Division shall not recapture the program's profit in the program's next fiscal year. The Division, in consultation with the PADs, reserves the right to deny approval under this section. The Division's decision under this section is not subject to review under the Division's rules.

However, if the Division reviews the program's subsequent funding application and determines that the program failed to reinvest the anticipated profit according to the program's description, the

Division shall recoup the anticipated profit by withholding the value of the anticipated profit from the program's claims until the State is made whole.

Finally, if a program has received extraordinary financial relief under these rules, the Division will recapture all PNMI profit by applying any net revenue against the current year's total allowable costs.