

**Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Complete text**

Note: These emergency regulations represent the complete text of the permanently-adopted “final” regulations as amended by emergency/proposed amendments effective July 2, 2014. (The text in this document is also the text of the regulations in effect on July 1 as an emergency regulation.) The text of the permanently-adopted “final” regulations and emergency/proposed amendments are available on the OPWDD website at www.opwdd.ny.gov. Look under “Regulations & Guidance.”

Effective date: Tuesday, July 1, 2014

- **14 NYCRR is amended by the addition of a new Part 641 and Subpart 641-1 as follows:**

Part 641. Rate Setting for Non-State Providers

Subpart 641-1. Rates for Non-State Providers of Residential Habilitation in Community Residences, Including Individualized Residential Alternatives (IRAs), and for Non-State Providers of Day Habilitation.

641-1.1. Applicability. On and after July 1, 2014, rates of reimbursement for residential habilitation services provided in community residences, including IRAs, and for day habilitation services, other than those provided by OPWDD, shall be determined in accordance with this Subpart.

641-1.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

(a) Allowable costs. In the case of residential habilitation services, costs that are allowable under sections 635-10.4 (b)(1) and 686.13(b), and Subpart 635-6 of this Title. In the case of day habilitation services, costs that are allowable under section 635-10.4(b)(2) and Subpart 635-6 of this Title.

(b) 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.

(c) Base year. The consolidated fiscal report period from which the initial period rate will be calculated. Such period shall be January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis and July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis.

(d) Base operating rate. Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.

Note: All new material.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(e) Community residence. A facility operated as a community residence under Part 686 of this Title, including an individualized residential alternative.

(f) Day habilitation services. Day habilitation services provided under the home and community based services waiver operated by the Office for People with Developmental Disabilities (OPWDD) and pursuant to Subpart 635-10 of this Title.

(g) Department of Health (DOH) Regions. Regions as defined by the New York State Department of Health (DOH), 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 subparagraphs (1), (2) or (3) of this paragraph.

(h) 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) Users' Guide*, and another document titled *Scoring the DDP* are 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.

(i) 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 DOH 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 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

- (2) OPWDD, Attention Public Access Officer, 44 Holland Avenue, Albany, NY 12229.
- (j) E-Score Factor. Factor derived from analysis of Evacuation Scores to adjust staffing needs necessary to address health and safety needs.
- (k) 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.
- (l) Individual. Person receiving a residential or day habilitation service.
- (m) Initial period. July 1, 2014 through June 30, 2015.
- (n) 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.
- (o) Occupancy factor. Beginning July 1, 2015 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.
- (p) 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.
- (q) 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 DOH 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 DOH has issued a Medicaid provider agreement.
- (r) Rate sheet capacity. The number of individuals for whom a provider is certified or approved by OPWDD to provide residential habilitation.
- (s) 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 Section 671.7 of this Title.
- (t) Residential habilitation. Residential habilitation services provided in a community residence, under the home and community based services waiver operated by OPWDD and pursuant to Subpart 635-10 and Part 671 of this Title.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

- (u) 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.
- (v) 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.
- (w) Total reimbursement – The Provider’s final reimbursement as calculated on their rate sheets inclusive of SSI/SNAP adjustments and State Supplement add-on.
- (x) 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

641-1.3. 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 641-1.8 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 DOH.
- (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,

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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 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 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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 –

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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 provider divided by the base year contracted clinical hours for each provider of 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)

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 30, 2014, 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, 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 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 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 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 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 a DOH region, aggregated for all

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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:

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.

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.

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 Subpart 635-6 of this Title or thresholds as determined pursuant to subparagraph (iv) of this paragraph. DOH may retroactively adjust the capital component.

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July 1, 2014.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(ii) Initial rate. The rate shall include the approved appraised costs of a lease or acquisition, 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 such costs, continuing until such time as actual costs are submitted to OPWDD. 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 OPWDD 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. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by OPWDD and supporting documentation of such costs shall be submitted to OPWDD, which shall transmit such information to DOH. 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 may be amortized over a 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 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 Subpart 635-6 of this Title. 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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(f) Lease costs. Allowable lease costs shall be determined in accordance with Subpart 635-6 of this Title.

(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

<i>Threshold for Residential Rental sites- leases less than 5-year term</i>				
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

<i>Heat Allowance For rentals which include Heat</i>	+ \$900	+\$1,200	+\$1,500	<i>4 or more +\$1,500 +\$300 additional</i>
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<i>Threshold for leases greater than 5 years</i>	
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

<i>Renovation costs for residential leases less than 5 years</i>	
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

Upstate (all other)	\$77,622
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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

<i>Residential Start-up Allowance per bed</i>		
Counties	New	Relocations
New York City, Suffolk, Nassau, Westchester, Putnam, Rockland	\$5,800	\$1,000
Rest of the State	\$5,500	\$900

Pre-Operational Rent Allowance

<i>Pre-operational rent allowance</i>		
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

\$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 \$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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

Soft costs

<i>Limited to the lesser of actual cost or threshold</i>
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 Subpart 635-6 of this Title. 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.

(v) 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 revenue, as determined by subparagraph (iii) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(ii) Supplemental security income, as determined by subparagraph 671.7(a)(9)(xxi) of this Title, annualized and multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by clause 671.7(a)(10)(i)(c) of this Title, 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 reimbursement offset amount will be added to a provider's total provider operating revenue-adjusted, as calculated in subparagraph (1)(xxix) of this subdivision. If such amount is positive, a provider shall receive the state supplemental 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 Total reimbursement from all provider rate sheets in effect on June 30, 2014 less the sum of total provider operating revenue-adjusted as calculated in subparagraph (1)(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 30, 2014 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.

(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 a DOH region,

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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 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 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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 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 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 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 provider divided by the base year contracted clinical hours for each provider of 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 30, 2014, 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 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 a DOH region, aggregated for all such providers in such region divided by twelve.

(ii) The product should 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 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 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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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.

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 a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial period.

The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, 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 Subpart 635-6 of this Title or the thresholds determined pursuant to subparagraph (iv) of this paragraph. DOH may retroactively adjust the capital component.

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July 1, 2014.

(ii) Initial rate. The rate shall include the approved appraised costs of a lease or acquisition, 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 such costs, continuing until such time as actual costs are submitted to OPWDD. 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

costs for a period no greater than two years. If actual costs are not submitted to OPWDD 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. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by OPWDD and supporting documentation of such costs shall be submitted to OPWDD, which shall transmit such information to DOH. 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 may be amortized over a 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 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 Subpart 635-6 of this Title. 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 Subpart 635-6 of this Title.

(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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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

<i>Threshold for Residential Rental sites- leases less than 5-year term</i>				
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
<i>Heat Allowance For rentals which include Heat</i>	<i>+\$900</i>	<i>+\$1,200</i>	<i>+\$1,500</i>	<i>4 or more +\$1,500 +\$300 additional</i>

<i>Threshold for leases greater than 5 years</i>	
New York City	\$13,217 per bed
Westchester, Nassau, Rockland and Suffolk Counties	\$10,548 per bed

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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

<i>Renovation costs for residential leases less than 5 years</i>	
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 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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

<i>Residential Start-up Allowance per bed</i>			
Counties	New		Relocations
New York City, Suffolk, Nassau, Westchester, Putnam, Rockland	\$5,100		\$1,000
Rest of the State	\$4,900		\$900

Pre-Operational Rent Allowance

<i>Pre-operational rent allowance</i>		
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

\$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 \$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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

Soft costs

<i>Limited to the lesser of actual cost or threshold</i>
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 Subpart 635-6 of this Title. 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.

(v) 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 revenue, as determined by subparagraph (iii) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(ii) Supplemental security income, as determined by subparagraph 671.7(a)(9)(xxi) of this Title, annualized and multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by subparagraph 671.7(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 reimbursement offset amount will be added to a provider's total provider operating revenue-adjusted, as calculated in subparagraph (1)(xxix), of this subdivision. If such amount is positive, a provider shall receive the state supplemental 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 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 subparagraph (1)(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.

(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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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 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 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 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 of 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 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 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.

(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 divided by the base year contracted clinical hours for each provider of 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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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 30, 2014, divided by provider

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider of 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 a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider of 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 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 a DOH region, aggregated for all such providers in such region.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July 1, 2014.

(ii) Initial rate. 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 OPWDD. 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 OPWDD within two years from the date of certification of estimated costs, reimbursement for capital costs shall be zero for each period in which actual costs are not submitted. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by OPWDD and supporting documentation of such costs shall be submitted to OPWDD, which shall transmit such information to DOH. 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. In no circumstances shall reimbursement under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph. Reimbursement may be amortized over a 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. Start-up costs may be amortized over a one year period beginning with certification. Limitations on such costs to be included in the rate shall be the following:

(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.

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

- (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 sites.
- (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. 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 and not included

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

(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. Thresholds shall be determined pursuant to the following:

Capital Thresholds for Day Program Leased Space- New Space/Site

<i>Threshold for Day Program Leased Space (Rentals)</i>	
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

Capital Thresholds for Day Program Acquisitions including Relocations

<i>Day Program Acquisition and Rehabilitation/New Construction Costs, Including relocations</i>	
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

<i>Day Program Start-Up Allowance</i>	
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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 \$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 \$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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

\$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
\$10,000,000	To be negotiated	

Soft costs

<i>Soft costs</i>
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 amount approved by OPWDD
Soil inspection at amount approved by OPWDD
Security at amount approved by OPWDD

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

641-1.4. Reporting requirements.

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

(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).

641-1.5. Trend Factor. For years in which DOH does not update the base year, subject to the approval of the Director of the Budget, DOH 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.

641-1.6. 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 1st to the following June 30th, 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 as determined by the reimbursement methodology described in this subpart, 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.

Transition Year	Phase-in Percentage	
	Base operating rate	New Methodology
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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

period beginning July 1, 2014 through June 30, 2015, providers that receive reimbursement of residential habilitation in supervised community residences pursuant to this Subpart shall determine and report to DOH 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.

(i) Retainer days shall be reimbursed at zero dollars.

(ii) At the mid-point and again at the conclusion of the period ending June 30, 2015, DOH 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.

(iii) Providers shall not be paid for more than fourteen retainer days per annual period for any one individual.

(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 conclusion of the period ending June 30, 2015, 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.

(c) For periods subsequent to June 30, 2015:

(1) The daily rate, as determined pursuant to this Subpart, excluding section 641-1.8 will be adjusted to include an occupancy factor.

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

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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

641-1.7. 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 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 Department of Health its request by certified mail, return receipt requested, within 90 days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

641-1.8. Specialized template populations. Notwithstanding any other provision of this Subpart, rates for individuals identified by OPWDD as qualifying for specialized template populations funding shall be as follows:

- (a) For individuals initially identified as qualifying for specialized template populations funding between November 1, 2011 and March 31, 2014

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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

Upstate	\$123,500
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Day Hab – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual Operating only
Downstate	\$41,730
Upstate	\$37,562

Day Hab – 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 31, 2014

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

**Emergency Regulations: Rate Setting for Non-State Providers:
IRA/CR Residential Habilitation and Day Habilitation
Effective: July 1, 2014**

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

641-1.9. 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.