

1. The reasonable direct cost per Medicaid/NJ Kid-Care fee-for-service case for those hospitals receiving rates in accordance with this subchapter for every DRG shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:

i. Effective for services provided prior to October 1, 1996, the incentive standard is multiplied by the unequalization factor, the physician mark-up, the denuclearization factor, and Residents adjustment factor.

ii. Effective for services provided on or after October 1, 1996, the incentive standard is multiplied by the unequalization factor and the physician mark-up.

(b) Inpatient outliers: The costs of low length of stay outliers shall be divided by the low length of stay days to arrive at a low per diem. The costs of high length of stay outliers shall be divided between both high outlier cost and the inlier rate. The high outlier cost net of the inlier rate times the high outlier cases shall be divided by the acute days of the patient's total stay (admission to discharge) to arrive at a high outlier per diem. High outlier cases shall be reimbursed the inlier rate plus the high per diem multiplied by the acute days of the stay.

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

In (a)li, inserted text "Effective for services provided prior to October 1, 1996"; and added (a)lii.

Recodified from N.J.A.C. 10:52-5.15 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (a)l, inserted a reference to NJ KidCare fee-for-service cases. Former N.J.A.C. 10:52-5.11, Identification of direct and indirect costs related to Medicaid patient care, recodified to N.J.A.C. 10:52-5.7.

#### 10:52-5.12 Net income from other sources

(a) The net gain (loss) from Other Operating and Non Operating Revenues (as defined in N.J.A.C. 10:52-6.25 through 6.32) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 10:52-6.25 through 6.32) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in N.J.A.C. 10:52-6.25 through 6.32.

Recodified from N.J.A.C. 10:52-5.16 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Changed N.J.A.C. references throughout. Former N.J.A.C. 10:52-5.12, Patient care cost findings; direct costs per case, physician and nonphysician, recodified to N.J.A.C. 10:52-5.8.

#### 10:52-5.13 Update factors

(a) The economic factor is the measure of the change in prices of goods and services used by New Jersey hospitals. The economic factor will be the factor recognized under the TEFRA target limitations.

(b) The technology factor takes into account the costs of adopting quality enhancing technologies.

1. The hospital-specific economic factor is the weighted average of the recorded and projected change in the value of its components. The weight given to each component is its share of that hospital's total expenditure. The projection of individual components shall be based, where appropriate, on legal or regulatory changes which fix the future value of a proxy. Components which are of particular importance may be projected through the use of time series analysis on other relevant indicators.

(c) Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies. The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost-increasing technologies, and ProPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC.

(d) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be \$72,139 in 1988 dollars.

2. Heart Transplants: payment for DRG 103 will be \$72,438 in 1988 dollars.

3. Cochlear Implants: payment for DRG 759 will be \$21,608 in 1988 dollars.

4. Bone Marrow Transplants: payment for DRG 481 will be \$46,599 in 1988 dollars.

5. Neonate rates: payment for neonatal DRGs as defined by New Jersey Grouper 8.0 will be based on 1989 actual New Jersey patient volume.

(e) For determination of the payment rates, direct patient care is increased for the following components:

1. Indirect patient care for items other than listed in N.J.A.C. 10:52-5.7;

2. Health Planning fees;

3. Capital facilities allowance;

4. Physician fee for service;
5. Child psychiatric hospital direct and indirect;
6. Resident count correction (only for services provided prior to October 1, 1996).
7. Special perinatal expense adjustment;
8. Trauma center adjustment;
9. GME reversal (only for services provided prior to October 1, 1996);
10. Hemophilia adjustment;
11. Regional perinatal adjustment;
12. Personnel health allowance;
13. Pediatric rate adjustment;
14. Sickle cell adjustment;
15. Continuous adjustments;
16. Outlier reversal adjustment; and
17. Poison Control Costs.

(f) No Statewide transition adjustment not otherwise specified in this chapter will be included in the rate.

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

In (a)6 and (a)9, added text "(only for services provided prior to October 1, 1996)".

Recodified from N.J.A.C. 10:52-5.17 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (e)1, changed N.J.A.C. reference. Former N.J.A.C. 10:52-5.13, Reasonable cost of services related to patient care, recodified to N.J.A.C. 10:52-5.9.

#### 10:52-5.14 Capital facilities

(a) Capital Facilities, as defined in N.J.A.C. 10:52-6.18, shall be included in the rate in the following manner:

##### 1. Building and fixed equipment:

i. The yearly Capital Facilities Allowance is computed using information provided by the Share Cost Reports. For hospitals on a calendar year basis, this amount will be its 1992 depreciation and interest expense, excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery. For those hospitals on a fiscal year basis, actual year's depreciation and interest applicable to rate year 1992 shall be used excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery.

ii. Effective for services provided on or after October 1, 1996, all building and fixed depreciation and interest capital costs as defined in N.J.A.C. 10:52-6.18 related to GME programs shall be determined based on the 1992 audited Medicare Cost Report (HCFA-2552) and shall be excluded from the base year cost used to calculate the Medicaid DRG inpatient rates.

2. Major Moveable Equipment: For the purpose of calculating the Price Level Depreciation Allowance, Major Moveable Equipment is grouped into four categories based on the cost center function where the equipment is utilized: Beds and nursing equipment; Diagnostic and therapeutic equipment; General service equipment; and Business service equipment.

i. The following rules shall apply in calculating the Price Level Allowance for a given year:

(1) Only equipment which has not been fully depreciated at the start of the fiscal year is to be used in the calculation of the Price Level Allowance.

(2) The depreciation recorded and reported on all equipment subject to the Price Level Allowance must be calculated by the straight-line method, using at the time of the cost filing the most recent approved American Hospital Association (AHA) Recommended Useful Life (that is, 1978 revision) or Asset Depreciation Range (ADR).

(3) Only capitalized equipment and related capitalized costs can be used in the calculation of the Price Level Allowance.

(4) The price level factors for each of the four categories will be developed by the Division. For years prior to current cost base year, the factors to be used for price leveling depreciation are as follows:

Category	Proxy
Beds and Nursing Equipment	Marshall and Swift Hospital Equipment Cost Index
Diagnostic and Therapeutic Equipment	Marshall and Swift Hospital Equipment Cost Index
General Service Equipment	Producer Price Index (PPI) 1161, Food Products Machinery (41.18%), PPI 1241.02, Laundry Equipment (23.53%), PPI 113 less 1134 and 1136, Metalworking Machinery less Industrial Furnaces and Abrasive Products (35.29%).
Business Service Equipment	PPI 1193 less 1193.06, Business and Store equipment (less Coin Operated Vending Machines) and PPI 122, Commercial Furniture.

(5) Assets retired before the close of the fiscal year are not to be used in the calculation of the Price Level Allowance.

(6) The amount of the Price Level Allowance shall be calculated as follows:

(A) Current year straight-line depreciation of each asset being depreciated is multiplied by the price level factor corresponding to the year the asset was acquired to determine price level depreciation. Straight-line depreciation is then subtracted from price level depreciation and the result totaled to determine the amount of the Price Level Allowance provided by the following calculation: Algebraically the calculation is as follows:

- D ... (equals) Current year depreciation, ordered by the year of acquisition of the asset being depreciated.  
 F ... (equals) Price level factor for the year the asset was acquired.  
 PLA ... (equals) Price Level Allowance.  
 PLA ... (equals)  $(D \times F) - D$ .

(7) The interest component of cash disbursements relative to capitalized Major Moveable Equipment leases is to be classified as interest expense, in accordance with GAAP, and not used as a basis for calculating the price level depreciation premium.

(8) The total Price Level Allowance will be allocated to cost centers based upon the accumulated depreciation of all Major Moveable Equipment not fully depreciated.

(b) Any new capital facilities construction with valid certificate of need from the New Jersey Department of Health and Senior Services may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52-8 except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i. The appeal is for a single capital project in excess of \$20 million which is for replacement beds which reduce the number of hospital beds available in the State and as of September 15, 1997, the hospital has an approved certificate of need for this project;

ii. The hospital receives no direct State appropriation; and

iii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. If all of the conditions in (b)1 above are met, the hospital shall submit all supporting documentation to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Provider Rate Setting, PO Box 712, Mail Code #25, Trenton, New Jersey 08625-0712. The Division shall issue a written determination once the supporting documentation is reviewed and the hospital may appeal the determination pursuant to N.J.A.C. 10:52-8.1(d).

3. In addition to an adjustment to its rates, a hospital which meets the condition of (b)1 above shall receive an additional payment for its Capital Project Funding related to its Medicaid and NJ KidCare-Plan A managed care utilization.

i. Payments to eligible hospitals shall begin the calendar year following project completion and facility operation. These hospitals shall receive a lump sum payment for Capital Project Funding each month. The monthly payment shall be one-twelfth of the approved annual amount.

ii. The hospital-specific Capital Project Funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid and NJ KidCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Deleted (a)1i, relating to capital cash requirements; recodified former (a)1ii as (a)1i and deleted subparagraph 1 of that paragraph; and inserted new (a)1ii.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).

In (b), added the exception; and added (b)1 and (b)2.

Amended by R.1998 d.340, effective July 6, 1998.

See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).

Added (b)3.

Recodified from N.J.A.C. 10:52-5.18 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (b), changed N.J.A.C. references throughout, and substituted a reference to the Office of Provider Rate Setting for a reference to Administrative and Financial Services in 2. Former N.J.A.C. 10:52-5.14, Standard costs per case, recodified to N.J.A.C. 10:52-5.10.

### 10:52-5.15 Division adjustments and approvals

(a) Any modifications including any statutory or regulatory changes or changes in patient care physician compensation arrangements shall be classified as direct or indirect and as to the financial elements affected and each element adjusted proportionately.

(b) The Division shall also approve adjustments to hospitals' Schedules of Rates for 1993 and subsequent years as necessary to subtract approved costs associated with residents not meeting the minimum requirements as defined in N.J.A.C. 10:52-5.10(b); for any costs associated with resi

dents in programs which have lost accreditation as defined in N.J.A.C. 10:52-5.10(b); and for any costs associated with previously approved but now vacant residency positions which are unfilled as a result of a hospital's inability to recruit residents meeting these minimum standards. These costs shall include, but are not limited to, resident salaries and fringes, faculty salaries, malpractice and supplies.

(c) The Division may approve hospital appeals to transfer Division approved resident positions and associated costs between hospitals. A hospital may appeal under any option to reduce or increase the number of resident positions by transfer. An addition of resident positions by transfer may not result in a change to a higher teaching status peer group. A reduction of resident positions by transfer may result in a change to a lower teacher status peer group. The approved costs associated with a transferred resident position may not increase solely as a result of the transfer.

(d) The Division shall decide to which hospitals the approved resident positions and associated costs may be transferred.

(e) Subsections (a) through (d) above apply for dates of services provided prior to October 1, 1996. Effective for services provided on or after October 1, 1996, this section is no longer applicable.

Amended by R.1997 d.43, effective January 21, 1997.  
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Added (e).  
Recodified from N.J.A.C. 10:52-5.19 and amended by R.2000 d.29, effective January 18, 2000.  
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (b), changed N.J.A.C. references throughout. Former N.J.A.C. 10:52-5.15, Reasonable direct cost per case, recodified to N.J.A.C. 10:52-5.11.

#### 10:52-5.16 Derivation from Preliminary Cost Base

(a) Apportionment of Financial Elements based on direct costs shall be as follows:

1. All other Financial Elements are added to direct Medicaid/NJ KidCare fee-for-service patient care costs as percentages of direct costs per Medicaid/NJ KidCare case. The Schedule of Rates is set such that all Medicaid/NJ KidCare patients' rates are based on the cost of services received by Medicaid /NJ KidCare fee-for-service beneficiaries, including a proportionate share of indirect financial elements requirements of operating hospital facilities.

2. In the event that a hospital is self-insured for employee health benefits, the percentage of personnel health allowance recognized in the rates shall be proportioned to the number of Medicaid /NJ KidCare fee-for-service beneficiaries serviced by the facility to financial elements from payers for such costs.

3. Each hospital shall receive from the Division a base rate order detailing the Schedule of Rates.

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Recodified from N.J.A.C. 10:52-5.20 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (a), substituted a reference to Medicaid NJ KidCare fee-for-service patient care costs for a reference to Medicaid patient care costs, inserted a reference to NJ KidCare cases, and substituted a reference to Medicaid/NJ KidCare patients' rates for a reference to Medicaid patients' rates in 1, and substituted references to Medicaid and NJ KidCare fee-for-service beneficiaries for references to Medicaid recipients in 1 and 2. Former N.J.A.C. 10:52-5.16, Net income from other sources, recodified to N.J.A.C. 10:52-5.12.

#### 10:52-5.17 Schedule of rates—effective date

All rates issued pursuant to this subchapter, as approved or modified, shall be effective as of October 1, 1996, of the rate year and then January 31 for subsequent years except for fiscal year hospitals whose rates shall be effective as of the first day of the "fiscal" rate year.

Amended by R.1997 d.43, effective January 21, 1997.

See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Amended effective date.

Recodified from N.J.A.C. 10:52-5.21 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Substituted a reference to January 31 for a reference to January 1. Former N.J.A.C. 10:52-5.17, Update factors, recodified to N.J.A.C. 10:52-5.13.

#### 10:52-5.18 (Reserved)

Recodified to N.J.A.C. 10:52-5.14 by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

#### 10:52-5.19 (Reserved)

Recodified to N.J.A.C. 10:52-5.15 by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

#### 10:52-5.20 (Reserved)

Recodified to N.J.A.C. 10:52-5.16 by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

#### 10:52-5.21 (Reserved)

Recodified to N.J.A.C. 10:52-5.17 by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

### SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

#### 10:52-6.1 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare reporting in the year prior to the hospital's first Medicaid/NJ KidCare fee-for-service rate.