

Integrated Testimony for the Public Hearing on 957 CMR 7.00:

Nursing Facilities Cost Reporting Requirements

**To: Center for Health Information and Analysis (CHIA)**

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CMR 7.00

**EXECUTIVE SUMMARY**

Dignity Alliance Massachusetts strongly supports the proposed amendments to 957 CMR 7.00. Facility-level cost reports, as currently structured, lack construct validity for evaluating the true economic performance of nursing home ownership entities. Without parent-company and related-party transparency, CHIA’s data collection risks validating an accounting fiction that systematically understates investor returns while overstating operating distress. The proposed amendments are necessary to restore analytic integrity, protect Medicaid funds, and enable meaningful correlation between financial practices and quality of care. This testimony integrates findings and arguments developed in published work on private equity extraction, long-term care economic justice, and digital governance in health and human services (Lomastro, 2025a; 2025d; 2025e; 2025h; 2025j). That body of work demonstrates that financial opacity and financially-driven efficiency narratives often function to concentrate control and accelerate capital extraction rather than improve care quality.

**I. THE FALLACY OF “NET OPERATING INCOME” AS A MEASURE OF SECTOR HEALTH**

As documented in the financial research of David E. Kingsley, PhD, contemporary nursing home ownership structures render facility-level net operating income an unreliable indicator of economic performance. The industry’s repeated claim that

Medicaid reimbursement fails to cover “costs” rests on a flawed and manipulable construct of cost.

On Form G-3 and Form A-1, Line 89, Column 7, reported costs frequently include:

- Non-cash depreciation
- Interest payments tied to leveraged real estate strategies
- Related-party management and service fees

These accounting entries reduce taxable income while preserving — or increasing — cash flow to parent entities. As Kingsley demonstrates in his critique of the federal ASPE nursing home cost study, such reporting mechanisms convert investor extraction into “allowable costs.” When only facility-level entities are visible to regulators, financial distress can be manufactured on paper while upstream entities prosper.

This concern parallels prior analyses showing how public reimbursement systems are routinely converted into upstream investor yield through accounting and contractual design rather than operational efficiency (Lomastro, 2025d; 2025e). Treating these flows as legitimate “costs” normalizes extraction as care expense and undermines regulatory intent.

## **II. THE OPCO / PROPCO / MANCO FINANCIAL ARCHITECTURE**

Modern nursing home chains typically operate through multi-entity corporate structures:

- OPCO (Operating Company): Holds the license and reports narrow or negative margins.
- PROPCO (Property Company): Owns real estate and charges inflated triple-net leases.
- MANCO (Management Company): Extracts fees for staffing, food, IT, maintenance, and “home office” services.

This transfer-pricing architecture allows profits to be legally reclassified as operating expenses. Medicaid revenue flows through the OPCO but is monetized by upstream affiliates through rent extraction, management fees, and debt instruments. Kingsley’s case analyses of the Ensign Group and Riverbend Post Acute demonstrate how this model amplifies Medicaid revenue into private cash flow while facility books continue to show “hardship.” The proposed amendments are essential because they finally extend CHIA’s analytic lens to Significant Equity Investors, where economic power and financial decision-making actually reside.

This multi-entity structure reflects the same extraction patterns documented across other social safety net systems, where ownership complexity is used to arbitrage public funding while insulating capital from accountability (Lomastro, 2025f; 2025g).

### **III. THE SCIENTIFIC DISTORTION OF POLICY THROUGH INADEQUATE DATA MODELS**

Policy debates often rely on studies using uni-level regression models that treat facilities as isolated units. Kingsley shows that this method ignores the “nesting” of facilities within:

- State regulatory regimes
- Ownership networks
- Capital financing structures

This produces statistically neat but substantively misleading conclusions. Massachusetts cannot evaluate the effectiveness of reimbursement policy, staffing mandates, or enforcement strategies if financial data is structurally mis-specified.

A more accurate approach requires Hierarchical Linear Modeling (HLM) that incorporates:

- Ownership tier
- Audit intensity
- Corporate integration

This analytic failure resembles has described as the “AI efficiency trap,” in which performance metrics and automation claims displace governance, workforce stability, and ethical accountability (Lomastro, 2025h; 2025i). Without ownership-tier data, even sophisticated analytics risk reinforcing the very structures that produce care instability.

### **IV. CLOSING THE OPACITY GAP IN OVERSIGHT**

The combination of weak auditing visibility and inaccessible related-party data creates an environment conducive to corporate capture of regulatory processes and financial abuse. Requiring audited financial statements from management companies and equity investors is the only way to determine whether:

- Medicaid dollars are funding direct care
- Or being converted into debt leverage and investor yield

This is not a marginal technical adjustment. It is foundational to the integrity of public financing.

## **V. SYSTEMIC HARM AND THE HUMAN STAKES**

Financial opacity is not an abstract accounting problem. It directly correlates with human suffering. The Genesis Healthcare bankruptcy proceedings and the repeated “worst of the worst” citations at Fall River Healthcare illustrate how complex ownership structures obstruct accountability when facilities fail. When regulators cannot see upstream cash flows, they cannot intervene before clinical collapse occurs. As Dr. Louise Aronson argues in *Elderhood*, we have created institutional “holding areas” rather than environments of humane, relational care. Financial transparency is a clinical reform tool.

When extraction is visible, investment priorities can shift toward:

- Stable staffing
- Sensory-supportive environments
- Slow medicine and individualized care

The clinical consequences of financial extraction are inseparable from what has been described as the “age-friendly paradox,” where systems advertise inclusion while operational practices systematically degrade continuity, staffing, and human connection (Lomastro, 2025j; 2025k).

## **VI. COST AND EFFICIENCY: AI-ENABLED REGULATORY OVERSIGHT**

A common concern raised about expanded financial disclosure requirements is whether additional oversight will increase administrative costs for the Commonwealth. That concern is understandable but increasingly outdated. Modern regulatory analytics can be substantially augmented through off-the-shelf artificial intelligence (AI) and rule-based automation, allowing agencies to scale oversight capacity without proportional increases in staffing or contractor expenditures.

Contemporary regulatory agencies in taxation, banking, and healthcare already use anomaly detection systems to flag often in real time

- Missing, false or inconsistent filings
- Outlier ratios (e.g., rent-to-revenue, management fees, intercompany transfers)
- Rapid shifts in financial patterns that suggest restructuring or asset stripping

These systems do not replace professional judgment; they prioritize staff attention where risk is highest. This is consistent with what Lomastro (2025h; 2025i) describes as governance-supporting AI rather than labor-replacing automation.

Failure to modernize analytic infrastructure creates what Lomastro (2025j) terms technical debt in public systems — legacy reporting requirements that generate data but do not produce actionable intelligence. By contrast, AI-assisted pattern recognition can convert existing filings into proactive oversight tools that can augment analysts sparing them the tedious gymnastic of corporate accountant and financial managers

Once implemented, analytic agents could support collaboration between CHIA, the Department of Public Health, and the Attorney General by:

- Linking financial extraction patterns to staffing shortfalls and citation histories
- Flagging facilities entering financial distress for pre-emptive monitoring instead of waiting for them to close. Simple reports such as cash on hand would do it. At one Long Term Commission meeting, it was reported that the industry average only a few days' worth of cash available on hand. Cash is what pays staff, utilities and supplies.
- Supporting enforcement of direct-care spending and related-party disclosure rules

## **VII. COST OF OVERSIGHT VS. COST OF COLLAPSE — THE STEWARD WARNING**

Even modest investments in analytic oversight are far less costly than the downstream consequences of healthcare system failures driven by financial extraction. The recent Steward Health Care crisis demonstrates how asset stripping, leveraged real estate transactions, and upstream profit extraction can destabilize entire regional care systems. When operating entities are left financially hollowed out, the public ultimately absorbs the cost through emergency funding, hospital closures, service disruptions, and workforce displacement.

A comparable dynamic now threatens long-term care. If systemic extraction from nursing facilities continues unchecked, Massachusetts could face cascading failures affecting not dozens, but tens of thousands of residents. With approximately 30,000 nursing facility residents statewide, even a disruption affecting 10–15 percent of beds would displace 3,000 to 4,500 medically fragile residents with few safe placement options.

Such displacement would place immediate pressure on acute care hospitals already operating near capacity, particularly during respiratory illness seasons. Emergency departments would become default placement sites, increasing boarding times, delaying elective procedures, and driving up Medicaid and uncompensated care costs across the system.

Beyond healthcare system strain, large-scale facility failures would expose the Commonwealth to direct budgetary risk through emergency appropriations, supplemental MassHealth payments, temporary management contracts, and potential state-backed stabilization measures, as seen during prior hospital and facility interventions.

Facility collapse also destabilizes the long-term care workforce. Sudden closures displace certified nursing assistants, nurses, therapists, and support staff, many of whom already face low wages and high turnover. Workforce instability accelerates regional staffing shortages, increases reliance on agency labor, and raises reimbursement costs across remaining facilities.

When large chains or heavily leveraged operators collapse, the Commonwealth bears immediate and long-term costs, including:

- Emergency resident relocation and transportation
- Temporary management contracts or receivership
- Increased hospitalizations due to care disruptions
- Accelerated Medicaid spending when residents lose stable placements
- Legal, administrative, and enforcement expenditures

These costs are not theoretical. Prior closures and bankruptcies have required state intervention to maintain continuity of care, often under crisis conditions where both fiscal efficiency and resident dignity are compromised.

By contrast, earlier detection of financial instability — such as escalating related-party rent, rising management fee ratios, or rapid debt accumulation — allows regulators to:

- Increase monitoring before quality deteriorates
- Intervene while corrective action is still possible
- Prevent sudden closures that shift private risk onto public systems

In this sense, financial transparency functions as preventive infrastructure. It reduces the likelihood that the Commonwealth must respond to emergencies rather than manage risk proactively. The marginal cost of enhanced data analysis is therefore an investment in fiscal stability, not an expansion of bureaucracy.

## VIII. RECOMMENDATIONS FOR FINAL IMPLEMENTATION

Dignity Alliance Massachusetts urges CHIA to ensure that final regulations include:

### 1. Mandatory Audited Financials

Audits of management and parent entities must remain non-negotiable and standardized.

### 2. Public Transparency

Ownership and related-party data should be made publicly accessible through CompareCare or equivalent platforms, consistent with the State Auditor's recommendations. They need to be in flat files allowing public entities and advocacy access.

### 3. Quality Linkage

CHIA should collaborate with DPH to correlate financial extraction patterns with:

- Staffing levels
- Complaint rates
- Serious deficiency citations

Only then can the Commonwealth empirically demonstrate the relationship between financial practices and resident harm.

### 4. Enforcement and Sanctions Must Follow the Money.

Cost reporting requirements without meaningful, enforceable sanctions risk becoming symbolic rather than protective. When penalties attach only to the licensed facility while profits are extracted through related management companies, real estate affiliates, and parent holding entities, enforcement does not alter business behavior. If fines function like parking tickets—where the cost of noncompliance is lower than the cost of compliance, such as meeting state-mandated minimum staffing levels—then they become a rational business expense rather than a deterrent. Modest administrative penalties are easily absorbed by private equity-backed chains. For financial transparency to function as true risk regulation, accountability must extend to the entities that control capital flows. This includes escalating penalties for repeated noncompliance, mandatory corrective action plans, and referral thresholds to MassHealth, DPH, and the Attorney General when reporting failures or abusive related-party transactions are identified. Without enforcement mechanisms that reach upstream ownership, reporting alone cannot prevent financial practices that ultimately jeopardize resident care and public funds.

## CONCLUSION

We must move beyond a regulatory model that treats nursing facilities as financially independent actors when they are, in fact, operational nodes within complex investment structures.

If “cost” continues to be defined only at the facility level, it will remain a cloak for investor return rather than a measure of care investment. CHIA now has the opportunity — and the obligation — to ensure that public dollars serve public purposes.

By adopting the proposed amendments to 957 CMR 7.00 in their strongest form, Massachusetts can set a national standard for financial accountability in long-term care.

Respectfully submitted,

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