CHAPTER 9549
DEPARTMENT OF HUMAN SERVICES
NURSING HOME PAYMENT RATE DETERMINATION

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9549.0050 SCOPE.

Parts 9549.0050 to 9549.0059 establish procedures for determining the operating cost payment rates for all nursing homes participating in the medical assistance program. Parts 9549.0050 to 9549.0059 are effective for rate years beginning on or after July 1, 1987. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 are found in parts 4656.0010 to 4656.0090.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0051 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9549.0050 to 9549.0059, the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program under parts 4656.0010 to 4656.0090 and used for performing resident assessments.

Subp. 3. **Base year.** "Base year" means the reporting year ending September 30, 1984.

Subp. 4. **Case mix operating costs.** "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category under part 9549.0053.

Subp. 5. **Discharge.** "Discharge" means a termination of placement in the nursing home that is documented in the discharge summary signed by the physician. For the purposes of this definition, discharge does not include:

A. a transfer within the nursing home unless the transfer is to a different licensure level; or

B. a leave of absence from the nursing home for treatment, therapeutic, or personal purposes when the resident is expected to return to the same nursing home.

Subp. 6. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 7. **Other care related operating costs.** "Other care related operating

costs" means the operating costs listed in part 9549.0040, subpart 6, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category, the cost of food, and the dietitian consulting fees calculated under part 9549.0053.

Subp. 8. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, excluding the cost of food and dietitian consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under part 9549.0053.

Subp. 9. **Productive nursing hours.** "Productive nursing hours" means all on duty hours of nurses, aides, orderlies, and attendants. The on duty hours of the director of nursing for facilities with more than 60 licensed beds and the on duty hours of any medical records personnel are not included. Vacation, holidays, sick leave, classroom training, and lunches are not included in productive nursing hours.

Subp. 10. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 11. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058.

Subp. 12. **Resident plan of care.** "Resident plan of care" for residents of nursing homes not licensed as boarding care homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing homes licensed as boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 13. **Short length of stay facility.** "Short length of stay facility" means a nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing home by dividing actual resident days in the skilled level of care for which the nursing home can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. 14. **Standardized resident days.** "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class listed in part 9549.0058. Standardized resident days must be determined under part 9549.0054, subpart 2.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0052 ESTABLISHMENT OF GEOGRAPHIC GROUPS.

Subpart 1. **Classification process.** The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 2 to 4.

Subp. 2. **Group 1.** All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 3. **Group 2.** All nursing homes in counties other than the counties listed under subparts 2 and 4 must be placed in geographic group 2.

Subp. 4. **Group 3.** All nursing homes in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, Saint Louis, Scott, and Washington counties must be placed in geographic group 3.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETITIAN CONSULTING FEES.

Subpart 1. **Fringe benefits and payroll taxes.** Fringe benefits and payroll taxes must be allocated to case mix, other care related costs, and other operating costs according to items A to E.

A. For the rate year beginning July 1, 1987, the allocation method in items B to E must be used. For the rate years beginning on or after July 1, 1988, all of the nursing home's fringe benefits and payroll taxes must be classified to the operating cost categories in part 9549.0040, subparts 1 to 6, based on direct identification. If direct identification cannot be used for all the nursing home's fringe benefits and payroll taxes, the allocation method in items B to E must be used.

B. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under part 9549.0040, subpart 5.

C. Fringe benefits and payroll taxes must be allocated to other care related costs in the same proportion to salaries reported under part 9549.0040, subpart 6.

D. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7.

E. For any nursing home that cannot separately report each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1), (2), (3), and (4).

(1) The commissioner shall sum the allowable salaries for all nursing homes separately reporting allowable salaries in each cost category, by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

(3) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for the nursing home under this item.

(4) If a nursing home's salary cost for any operating cost category in part 9549.0020, subpart 32, items A to G, is zero and the services provided to the nursing home in that operating cost category are not performed by a related organization, the nursing home must reclassify one dollar to a salary cost line in the operating cost category.

Subp. 2. **Determination of food costs.** The commissioner shall determine the costs of food to be included in other care related costs according to items A and B.

A. For any nursing home separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing home that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs. The nursing home's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing home.

Subp. 3. **Determination of dietitian consulting fees.** The commissioner shall determine the dietitian consulting fees to be included in other care related costs according to items A and B.

A. For any nursing home separately reporting dietitian consulting fees, the dietitian consulting fees shall be the allowable dietitian consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing home that has not separately reported dietitian consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietitian consulting fees for all nursing homes that separately reported dietitian consulting fees. The nursing home's total number of licensed beds must be multiplied by the average cost per bed to determine the dietitian consulting fees for the nursing home.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0054 DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs reported by the nursing home during the reporting year preceding the rate year to determine the nursing home's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080.

Subp. 2. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing home's standardized resident days must be determined in accordance with items A to C.

A. The nursing home's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058.

B. The amounts determined in item A must be summed to determine the nursing home's standardized resident days for the reporting year.

C. For the rate year beginning July 1, 1987, only, the nursing home's standardized resident days determined in item B must be multiplied by .99897.

Subp. 3. **Allowable historical case mix operating cost standardized per diem.** The allowable historical case mix operating cost standardized per diem must be computed by dividing the allowable historical case mix operating cost by the standardized resident days determined in subpart 2.

Subp. 4. **Allowable historical other care related operating cost per diem.** The allowable historical other care related operating cost per diem must be computed by dividing the allowable historical other care related operating costs by the number of resident days in the nursing home's reporting year.

Subp. 5. **Allowable historical other operating cost per diem.** The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the number of resident days in the nursing home's reporting year.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care related operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the case mix and other care related operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Case Mix and Care Related Components and Indexes

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies.
Food	.1183	Producer Price Index for consumer foods.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the other operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Other Operating Costs Components and Indexes

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central states (20 percent).
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 the base year operating costs limits must be determined according to items A to E. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix operating cost standardized per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care related per diems for the base year by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other care related operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B. The total care related operating cost limit for a short length of stay facility must be 125 percent of the total care related operating cost limit. A nursing home licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 is exempt from the total care related operating cost limit.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative. For the purpose of computing the amount of disallowed general and administrative cost, the nursing home's professional liability and property insurance must be excluded from the general and administrative cost category. For purposes of this item, the term property insurance means general liability coverage for personal injury incurred on the nursing home property and coverage against loss or damage to the building, building contents, and the property of others on the premises of the nursing home. Property insurance does not include any coverage for items such as automobiles, loss of earnings, and extra expenses.

E. The other operating costs limits must be determined in accordance with subitems (1) to (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

(1) For each geographic group in part 9549.0052, the commissioner shall group all hospital attached nursing homes, short length of stay facilities, and nursing homes licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing homes in each geographic group in part 9549.0052 must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing home in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all short length of stay facilities and nursing homes licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 in each geographic group in part 9549.0052 must be 105 percent of the limit established in subitem (2).

(4) For each geographic group in part 9549.0052, the commissioner shall group all nursing homes not included in subitem (1).

(5) The other operating cost limit for each group established in subitem (4) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing home in the group for the base year.

Subp. 3. **Indexed limits.** For a rate year beginning on or after July 1, 1987, the total care related operating cost limits and the other operating cost limits must be determined under items A and B.

A. The total care related operating cost limits must be determined under subitems (1) and (2).

(1) The composite price index for case mix and other care related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care related operating cost limits.

B. The total other operating costs limits must be determined under subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. 4. **Incorporations by reference.** The indexes specified in items A to D are incorporated by reference and are available through the Minitex interlibrary loan system. They are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. Standard Industrial Code 805 (SIC 805) is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair com-

modities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indexes," Bureau of Labor Statistics, United States Department of Labor.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0056 DETERMINATION OF OPERATING COST PAYMENT RATE.

Subpart 1. **Nonadjusted case mix and other care related payment rate.** For each nursing home, the nonadjusted case mix and other care related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem established in part 9549.0054, subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058.

B. The allowable historical other care related operating cost per diem established in part 9549.0054, subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted case mix and other care related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted case mix and other care related payment rate must be set at the limit.

Subp. 2. **Adjusted prospective case mix and other care related payment rate.** For each nursing home, the adjusted prospective case mix and other care related payment rate for each resident class must be the nonadjusted case mix and other care related payment rate multiplied by the case mix and other care related adjustment factor determined in part 9549.0055, subpart 1, item A. If the nursing home is eligible to receive the phase in in subpart 7, the phase in reduced by the amount of the efficiency incentive, if any, must be added to the adjusted prospective case mix and other care related payment rate.

Subp. 3. **Nonadjusted other operating cost payment rate.** The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is below the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. **Adjusted prospective other operating cost payment rate.** The adjusted prospective other operating cost payment rate must be determined according to items A to D.

A. Except as provided in item B, if the nursing home's nonadjusted other operating cost payment rate is below the limit for that group established

in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3 up to a maximum of two dollars per resident day.

B. For any short length of stay facility and any nursing home licensed on June 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 that is under the limits established in part 9549.0055, subpart 2, item E, subitem (3), as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, subitem (2), as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars per resident day.

C. If the nursing home's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, except as provided in subpart 7.

D. If the nursing home is eligible to receive the phase in in subpart 7, the phase in must be added to the adjusted prospective other operating cost payment rate.

Subp. 5. **Total operating cost payment rate.** The nursing home's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care related payment rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

Subp. 6. **One time adjustment.** Items A to F set forth the procedure to be applied to establish a one time adjustment to the nursing home's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one time adjustment to the case mix operating costs per diem, the nursing home or portion of the nursing home for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing home must not have received an interim or settle up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one time adjustment to case mix operating costs per diem, the nursing home must have submitted a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing home cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing home cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(2) A list of the number and type of staff positions including annual

hours worked, and related fringe benefits and payroll taxes for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing home will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing home receives a one time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted by the nursing home under item B to determine if the nursing home meets the criteria in subitems (1) to (5).

(1) The nursing home meets the criteria in item A.

(2) The nursing home has submitted the documentation required in item B.

(3) The nursing home provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing home cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing home's allowable historical case mix and other care related operating cost per diem plus the one time adjustment is less than the case mix and other care related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one time adjustment to the nursing home's payment rate. The one time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing home's productive nursing hours per standardized resident day for the reporting period ending September 30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing home's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing home's nursing cost per hour must be determined by dividing the nursing home's total allowable historical case mix operating costs by the nursing home's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing home's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing home's total operating costs payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing home's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058, subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care related payment rates for each corresponding resident class.

E. The one time adjustment determined in item D, subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051, subpart 5. The commissioner shall perform a fiscal review of the nursing home's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing home provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing home has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care related licensing or certification standards. Based on the results of the fiscal review and the information provided by the commissioner of health, the commissioner shall implement either subitem (1), (2), or (3).

(1) If the nursing home has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing home under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing home has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing home's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle up. The adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home at the same level until June 30, 1988.

F. The nursing home must record the costs associated with this subpart separately from other nursing home costs until the commissioner's fiscal and compliance review under item E establishes that the nursing home has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase in of rates.** Nursing home rate limits shall be phased in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0057 DETERMINATION OF INTERIM AND SETTLE UP OPERATING COST PAYMENT RATES.

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing home

must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing home, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059, except that:

A. The nursing home must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle up operating cost payment rate.** The settle up total operating cost payment rate must be determined according to items A to C.

A. The settle up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall

use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly constructed nursing home or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle up total operating cost payment rate is determined under this subpart.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0058 RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with part 9549.0059.

A. A resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.

C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitem (1) or (2):

(1) the resident or applicant is assessed to require tube feeding; or

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. The publication is available through the Minitex interlibrary loan system and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.

Subp. 2. **Resident classes.** The commissioner shall establish resident classes according to items A to K. The resident classes must be established based on the definitions in subpart 1.

A. A resident must be assigned to class A if the resident is assessed as:

(1) Low ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

B. A resident must be assigned to class B if the resident is assessed as:

(1) Low ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

C. A resident must be assigned to class C if the resident is assessed as:

(1) Low ADL; and

(2) defined special nursing.

D. A resident must be assigned to class D if the resident is assessed as:

(1) Medium ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

E. A resident must be assigned to class E if the resident is assessed as:

(1) Medium ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

F. A resident must be assigned to class F if the resident is assessed as:
(1) Medium ADL; and
(2) defined special nursing.

G. A resident must be assigned to class G if the resident is assessed as:
(1) High ADL;
(2) scoring less than three on the eating ADL;
(3) not defined special nursing; and
(4) not defined behavioral condition.

H. A resident must be assigned to class H if the resident is assessed as:
(1) High ADL;
(2) scoring less than three on the eating ADL;
(3) defined behavioral condition; and
(4) not defined special nursing.

I. A resident must be assigned to class I if the resident is assessed as:
(1) High ADL;
(2) scoring three or four on the eating ADL;
(3) not defined special nursing; and
(4) not defined neuromuscular condition.

J. A resident must be assigned to class J if the resident is assessed as:
(1) High ADL;
(2) scoring three or four on the eating ADL;
(3) not defined special nursing; and
(4) defined neuromuscular condition or scoring three or four on behavior.

K. A resident must be assigned to class K if the resident is assessed as:
(1) High ADL; and
(2) defined special nursing.

Subp. 3. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 2 according to items A to K.

A. Class A, 1.00;
B. Class B, 1.30;
C. Class C, 1.64;
D. Class D, 1.95;
E. Class E, 2.27;
F. Class F, 2.29;
G. Class G, 2.56;
H. Class H, 3.07;
I. Class I, 3.25;
J. Class J, 3.53;
K. Class K, 4.12.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 6*

History: *11 SR 1990*

9549.0059 RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing home applicants and newly admitted residents.** Each nursing home applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's class. The assessment must be conducted according to the procedures in items A to I.

A. The county preadmission screening team or hospital screening team

under contract with the county must assess all nursing home applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.091, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.091, except as provided in subitems (1) and (2).

(1) The public health nurse as defined in Minnesota Statutes, section 145A.02, subdivision 18, of the county preadmission screening team or the registered nurse case manager shall assess a nursing home applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) An applicant whose admission to the nursing home is for the purpose of receiving respite care services need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054, subpart 2, if the applicant has been classified by the Department of Health within the prior six month period. In this case, the resident class established by the Department of Health within the prior six month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.

B. Except as provided in item A, subitem 2, the nursing home must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.091, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing home that is licensed differently than the section the resident previously was placed in or a resident who has been transferred from another nursing home.

C. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing home.

D. Any resident who is required to be assessed by the preadmission screening team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home must be assessed by the nursing home. The nursing home must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. Each assessment that the nursing home is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QA&R procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

G. Within five working days following the assessment, the preadmission screening team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing home.

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing home as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing home.

Subp. 2. **Semiannual assessment by nursing homes.** Semiannual assessments of residents by the nursing home must be completed in accordance with items A to D.

A. A nursing home must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall assess each resident according to QA&R procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse performing the assessment shall sign the assessment form.

C. Within five working days of the completion of the nursing home's semiannual resident assessments, the nursing home must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, the residents' plans of care, and the nursing home's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing home must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.

D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.

Subp. 3. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.

Subp. 4. **Assessment upon return to the nursing home from a hospital.** Residents returning to a nursing home after hospitalization must be assessed according to items A to D.

A. A nursing home must assess any resident who has returned to the same nursing home after a hospital admission. The assessment must occur no more than five working days after the resident returns to the same nursing home.

B. In addition to the assessment required in item A, residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital unless the nursing home's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing home must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing home after a hospital admission. This request must include the assessment form and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with additional information needed to determine a resident's classification.

D. Any change in resident class due to an assessment provided under item A must be effective on the date the resident returns to the nursing home from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first of the month following the assessment.

Subp. 5. **Change in resident class due to audits of assessments of nursing home residents.** Any change in resident class due to a reclassification required by part 4656.0050 must be retroactive to the effective date of the assessment audited.

Subp. 6. **False information.** If the nursing home knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. 7. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under part 4656.0070.

Subp. 8. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4656.0070 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0070 must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. 9. **Resident access to assessments and documentation.** The nursing home must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing home resident or the resident's authorized representative according to items A to D.

A. The nursing home must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing home. The nursing home must include a notice that the nursing home has chosen to appeal the rates under part 9549.0080.

B. The nursing home must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Department of Health within five days of the receipt of the classification letter. When the private paying resident is not the person responsible for payment, the classification letter must be sent to the person responsible for payment. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

D. The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within three working days of receipt of a written request from the resident or the resident's authorized representative.

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subds 3a,6*

History: *11 SR 1990; L 1987 c 309 s 24; 13 SR 130*

9549.0060 DETERMINATION OF THE PROPERTY RELATED PAYMENT RATE.

[For text of subps 1 to 8, see M.R. 1987]

Subp. 9. **Building capital allowance for nursing homes with operating leases.** Except as provided in subpart 14, for rate years beginning after June 30, 1985,

the building capital allowance for nursing homes with operating lease costs incurred for buildings must be paid as determined by items A to C.

[For text of subpart 9, items A to D, see M.R. 1987]

E. The phrase "operating lease" does not include a nominal lease. For purposes of this subpart, a lease that meets the following conditions is considered a nominal lease:

(1) the annual lease payment in comparison to the rental value of the physical plant and depreciable equipment is a nominal amount, usually $1 per year;

(2) the length of the lease, including renewal provisions, reflects the intent of the lessor and lessee to lease the physical plant and depreciable equipment for the remainder of their useful lives;

(3) the lease agreement imposes a duty upon the lessee to make necessary improvements and to properly maintain the nursing home;

(4) the lease agreement has no restrictions on the free use of the nursing home by the lessee other than it must be used as a licensed nursing home; and

(5) the lease agreement must not require the furnishing of any indirect benefits to the lessor.

A nursing home leased with a nominal lease shall have its building capital allowance computed as in subpart 8. This item is effective for rate years beginning on or after July 1, 1988.

[For text of subp 10, see M.R. 1987]

Subp. 11. **Capacity days.** The number of capacity days is determined under items A to C.

[For text of subp 11, items A and B, see M.R. 1987]

C. The commissioner shall waive the requirements of item B if a nursing home agrees in writing to subitems (1) to (3).

[For text of subp 11, item C, subitems (1) and (2) see M.R. 1987]

(3) The nursing home shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the amount calculated under units (a) to (c).

(a) The nursing home's average total payment rate shall be determined by multiplying the total payment rate for each case mix resident class by the number of resident days for that class in the nursing home's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing home's reporting year.

(b) The nursing home's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under unit (a) by ten percent.

(c) The nursing home's single bedroom adjustment which must not exceed the amount computed in unit (b) must be added to each total payment rate established in part 9549.0070, subpart 1 to determine the nursing home's single bedroom payment rates.

[For text of subp 12, see M.R. 1987]

Subp. 13. **Determination of the property related payment rate.** The commissioner shall determine the property related payment rate according to items A to H.

[For text of subp 13, item A, see M.R. 1987]

B. The allowable historical property related per diem shall be established according to subitems (1) and (2).

[For text of subp 13, item B, subitem (1), see M.R. 1987]

(2) For rate years beginning after June 30, 1986, the historical property related cost per diem shall be the property related payment rate established for the previous rate year unless the nursing home's capacity days change. If the nursing home's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing home beds, a change in the election for computing capacity days as provided in subpart 11, or a change in the number of days in the reporting year, the historical property related per diem must be recalculated using the capacity days for the reporting year in which the change occurred.

[For text of subp 13, items C to H, see M.R. 1987]

[For text of subp 14, see M.R. 1987]

Statutory Authority: *MS s 256B.41 subd 1; 256B.431 subd 3a; 256B.502*
History: *11 SR 1989; 13 SR 130*