CHAPTER 9549
DEPARTMENT OF HUMAN SERVICES
NURSING FACILITY PAYMENT RATES

9549.0010 SCOPE.

Parts 9549.0010 to 9549.0080 establish procedures for determining the payment rates for nursing facilities participating in the medical assistance program.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*

9549.0020 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9549.0010 to 9549.0080 the following terms have the meanings given them.

Subp. 2. **Actual allowable historical operating cost.** "Actual allowable historical operating cost" means the operating costs incurred by the nursing facility and allowed by the commissioner for the most recent reporting year.

Subp. 3. **Addition.** "Addition" means an extension, enlargement, or expansion of the nursing facility for the purpose of increasing the number of licensed beds or improving resident care.

Subp. 4. **Applicable credit.** "Applicable credit" means a receipt or expense reduction as a result of a purchase discount, rebate, refund, allowance, public grant, beauty shop income, guest meals income, adjustment for overcharges, insurance claims settlement, recovered bad debts, or any other adjustment or income reducing the costs claimed by a nursing facility.

Subp. 5. **Appraised value.** "Appraised value" means the value of the nursing facility buildings, attached fixtures, and land improvements used directly for resident care as determined under part 9549.0060.

Subp. 6. **Attached fixtures.** "Attached fixtures" means equipment used directly for resident care affixed to the building and not easily movable as specified in the fixed equipment table of the depreciation guidelines.

Subp. 7. **Buildings.** "Buildings" means the physical plant used directly for resident care and licensed under Minnesota Statutes, chapter 144A or Minnesota Statutes, sections 144.50 to 144.56, and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the site if used directly for resident care. This definition does not include buildings or portions of buildings used by central, affiliated, or corporate offices.

Subp. 8. **Building capital allowance.** "Building capital allowance" means the component of the property-related payment rate which is denominated as a payment for the use of buildings, attached fixtures, and land improvements.

Subp. 9. **Capital assets.** "Capital assets" means a nursing facility's buildings, attached fixtures, land improvements, depreciable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

Subp. 10. **Commenced construction.** "Commenced construction" means the date on which a newly constructed nursing facility, or nursing facility with an increase in licensed beds of 50 percent or more, meets all the following conditions:

A. The final working drawings and specifications were approved by the commissioner of health.

B. The construction contracts were let.

C. A timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction.

D. All zoning and building permits have been issued.

E. Financing for the project was secured as evidenced by the issuance of a binding letter of commitment by the financial institution, sale of bonds, or other similarly binding agreements.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services.

Subp. 12. **Cost category.** "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, audit, cost control, and the determination of cost limitations.

Subp. 13. **Cost report.** "Cost report" means the document and supporting material specified by the commissioner and prepared by the nursing facility. The cost report includes the statistical, financial, and other relevant information required in part 9549.0041 for rate determination.

Subp. 14. **Deletion.** "Deletion" means the sale, destruction, or dismantling of a nursing facility capital asset or a portion of a nursing facility capital asset without subsequent replacement.

Subp. 15. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 16. **Depreciated replacement cost method.** "Depreciated replacement cost method" means the method of property appraisal which determines the value of a capital asset by establishing the replacement cost new reduced by depreciation. As used in this subpart and part 9549.0060:

A. "Replacement cost new" means the amount required to obtain a new asset of equivalent utility to that which exists, but built at current prices, with modern materials and according to current standards, designs, and layout.

B. "Depreciation" means a loss of utility and hence value caused by deterioration or physical depreciation such as wear and tear, decay, dry rot, cracks, encrustations, or structural defects; and functional obsolescence such as poor plan, mechanical inadequacy or overadequacy, and functional inadequacy or overadequacy due to size, style, or age.

Subp. 17. **Depreciable equipment.** "Depreciable equipment" means the standard movable care equipment and support service equipment generally used in nursing facilities. Depreciable equipment includes that equipment specified in the major movable equipment table of the depreciation guidelines.

Subp. 18. **Depreciation guidelines.** "Depreciation guidelines" means "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611 (Chicago: 1983). Except as provided in part 9549.0030, subpart 4, the useful lives in the depreciation guidelines must

not be used in the determination of the total payment rate. The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155.

Subp. 19. **Desk audit.** "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

Subp. 20. **Direct cost.** "Direct cost" means a cost that can be identified within a specific cost category without the use of allocation methods.

Subp. 21. **Equipment allowance.** "Equipment allowance" means the component of the property-related payment rate which is denominated as a payment for the use of depreciable equipment.

Subp. 22. **Field audit.** "Field audit" means the on-site examination, verification, and review of the financial records, statistical records, and related supporting documentation of the nursing facility and any related organization.

Subp. 23. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and an allowance for uniforms.

Subp. 24. **General and administrative costs.** "General and administrative costs" means the costs of administering the nursing facility as specified in part 9549.0040.

Subp. 25. **Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied the limit on general and administrative costs.

Subp. 26. **Hospital-attached nursing facility.** "Hospital-attached nursing facility" means a nursing facility which is under common ownership and operation with a licensed hospital and shares with the hospital the cost of common service areas such as nursing, dietary, housekeeping, laundry, plant operations, or administrative services and which is required to use the stepdown method of allocation by the Medicare program, title XVIII of the Social Security Act, provided that the stepdown results in part of the cost of the shared areas to be allocated between the hospital and the nursing facility, and that the stepdown numbers are the numbers used for Medicare reimbursement.

Subp. 27. **Indirect cost.** "Indirect cost" means a cost that is incurred for a common or joint purpose and is identified with more than one cost category but is not readily identified with a specific cost category.

Subp. 28. **Land improvement.** "Land improvement" means an improvement to the land surrounding the nursing facility directly used for resident care as specified in the land improvements table of the depreciation guidelines, if replacement of the land improvement is the responsibility of the nursing facility.

Subp. 29. **Medical assistance program.** "Medical assistance program" means the program which reimburses the cost of health care provided to eligible recipients pursuant to Minnesota Statutes, chapter 256B and United States Code, title 42, section 1396 et seq.

Subp. 30. **Necessary service.** "Necessary service" means a function pertinent to the nursing facility's operation which if not performed by the assigned individual would have required the nursing facility to employ or assign another individual to perform it.

Subp. 31. **Nursing facility.** "Nursing facility" means a facility licensed under Minnesota Statutes, chapter 144A or a boarding care facility licensed under Minnesota Statutes, sections 144.50 to 144.56.

Subp. 32. **Operating costs.** "Operating costs" means the costs of operating the nursing facility in compliance with licensure and certification standards. Operating cost categories are:

A. nursing, including nurses and nursing assistants training;

B. dietary;

C. laundry and linen;

D. housekeeping;

E. plant operation and maintenance;

F. other care-related services;

G. general and administrative;

H. payroll taxes, fringe benefits, and clerical training; and

I. real estate taxes and actual special assessments paid.

Subp. 33. **Payroll taxes.** "Payroll taxes" means the employer's share of social security withholding taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes or costs.

Subp. 34. **Preopening costs.** "Preopening costs" means the operating costs incurred prior to the admission of a resident to a newly constructed nursing facility.

Subp. 35. **Private paying resident.** "Private paying resident" means a nursing facility resident who is not a medical assistance program recipient for the date of service and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

Subp. 36. **Rate year.** "Rate year" means the state of Minnesota's fiscal year for which a payment rate is effective, from July 1 through the following June 30.

Subp. 37. **Real estate taxes and special assessments.** "Real estate taxes and special assessments" means the real estate tax liability shown on the annual property tax statement of the nursing facility for the calendar year during which the rate year begins and the actual special assessments and related interest paid during the reporting year. The term does not include personnel costs or fees for late payment.

Subp. 38. **Related organization.** "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subpart:

A. An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. A "close relative of an affiliate of a nursing facility" is an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

D. "Control" including the terms "controlling," "controlled by," and "under common control with" is the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

Subp. 39. **Repair.** "Repair" means the cost of labor and materials needed to restore an existing capital asset to sound condition after damage or malfunction or to maintain an existing capital asset in a usable condition.

Subp. 40. **Replacement.** "Replacement" means a renovation or substitution of an existing capital asset to improve its function or extend its useful life.

Subp. 41. **Reporting year.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing facility submits its cost report, and which is the basis for the determination of the payment rate for the following rate year.

Subp. 42. **Resident day or actual resident day.** "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed.

Subp. 43. **Top management personnel.** "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators and the nursing facility administrator, according to Minnesota Statutes, section 144A.04, subdivision 5 and any other person performing the function of such personnel. Persons performing functions only as nursing facility department heads are not included in this definition.

Subp. 44. **Total payment rate.** "Total payment rate" means the addition of the operating cost payment rate, the property-related payment rate, and the real estate tax and special assessments payment rate as established by the commissioner to pay for the care of residents in nursing facilities.

Subp. 45. **Useful life.** "Useful life" means the length of time an asset is expected to provide economic service before needing replacement.

Subp. 46. **Utility vehicle.** "Utility vehicle" means a vehicle specially equipped for purposes of nursing facility operations and not readily adaptable to personal use.

Subp. 47. **Vested.** "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

Subp. 48. **Working capital debt.** "Working capital debt" means debt incurred to finance nursing facility operating costs. Working capital debt does not include debt incurred to acquire or refinance a capital asset.

Subp. 49. **Working capital interest expense.** "Working capital interest expense" means the interest expense incurred on working capital debt during the reporting year.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*

9549.0030 COST ALLOCATION PROCEDURES.

Subpart 1. **Classification.** Classification of costs is the process of charging costs to the appropriate cost categories and compiling a total for each cost category to be recorded on the cost report. Nursing facilities shall classify their costs in accordance with the cost categories in part 9549.0040. Costs that cannot be specifically classified in a cost category, such as the cost of generic supplies, must be classified in the general and administrative cost category.

Subp. 2. **Identification.** Except for the salary costs of individuals with multiple duties, costs must be directly identified, without allocation, by routine classification of transactions when costs are recorded in the books and records of the nursing facility.

Subp. 3. **Personnel with multiple duties.** When a person other than top management personnel has multiple duties, the person's salary cost must be allocated to the cost categories on the basis of time distribution records that show actual time spent, or an accurate estimate of time spent on various activities. In a nursing facility of 60 or fewer beds, part of the salary or salaries of top management personnel may be allocated to other cost categories to the extent justified in time distribution records which show the actual time spent, or an accurate estimate of time spent on various activities. A nursing facility that chooses to estimate time spent must use a statistically valid method. Persons who serve in a dual capacity, including those who have only nominal top management responsibilities, shall directly identify their salaries to the appropriate cost categories. The salary of any person having more than nominal top management responsibilities must not be allocated.

Subp. 4. **Central, affiliated, or corporate office costs.** Cost allocation for central, affiliated, or corporate offices shall be governed by items A to F.

A. Central, affiliated, or corporate office costs representing services of consultants required by law or rule in areas including dietary, pharmacy, social services, or other resident care related activities may be allocated to the appropriate cost category, but only to the extent that those costs are directly identified by the nursing facility.

B. Except as provided in item A, central, affiliated, or corporate office costs must be allocated to the general and administrative cost category of each nursing facility within the group served by the central, affiliated, or corporate office according to subitems (1) to (5).

(1) All costs which can be directly identified with a specific nursing facility must be allocated to that nursing facility.

(2) All costs which can be directly identified with an operation unrelated to the nursing facility operations must be allocated to that unrelated operation.

(3) After the costs which can be directly identified pursuant to subitems (1) and (2) have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between nursing facility operations and unrelated operations based on the ratio of expenses.

(4) Next, operations which have nursing facilities both in Minnesota and outside of Minnesota must allocate the central, affiliated, or corporate office costs to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all nursing facility operations.

(5) Finally, the central, affiliated, or corporate costs allocated to all Minnesota nursing facilities must be allocated to each nursing facility based on resident days.

C. Central, affiliated, or corporate office property-related costs of capital assets used directly by the nursing facility in the provision of nursing facility services must be allocated to the nursing facilities which use the capital asset and must be reimbursed under part 9549.0060. Central, affiliated, or corporate office property-related costs of capital assets which are not used directly by the nursing facility in the provision of nursing facility services must be allocated to the general and administrative cost category of each nursing facility using the methods described in item B.

D. The useful life of a new capital asset maintained by a central, affiliated, or corporate office must be determined by applying one of the following schedules in subitem (1) or (2):

(1) the useful life of a building is 35 years; of land improvement is 20 years; of a major building improvement is the greater of 15 years or the remaining life of the principal capital asset; of depreciable equipment except vehicles is ten years; and of a vehicle is four years; or

(2) the depreciation guidelines.

E. The useful life of used capital assets maintained by a central, affiliated, or corporate office must be determined based on the physical condition of the used capital asset but the useful life of the used capital asset must not be less than one-half the useful life determined under item D.

F. The useful life of leasehold improvements maintained by a central, affiliated, or corporate office must be either the useful life of the improvement determined under item D or the remaining term of the lease, including renewal periods, whichever is shorter.

Subp. 5. **General and administrative costs.** Except as provided in subparts 3 and 4, general and administrative costs must not be allocated as direct or indirect costs to other cost categories.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; 11 SR 866; L 1992 c 513 art 7 s 136*

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subpart 1. **Allowable costs.** Only costs determined to be allowable under parts 9549.0010 to 9549.0080 shall be used to compute the total payment rate for nursing facilities participating in the medical assistance program.

Subp. 2. **Applicable credits.** Applicable credits must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost. Interest income, dividend income, and other investment income of the nursing facility or related organization are not applicable credits except to the extent that the interest expense on working capital debt is incurred and claimed as a reimbursable expense by the nursing facility or related organization. Interest income must not be offset against working capital interest expense if it relates to a bond sinking fund or a restricted fund as defined in part 9549.0060, subpart 7, item B, or other restricted fund if the income is not available to the nursing facility or related organization. Gains or losses on the sales of capital assets used by the nursing facility must not be applicable credits.

Subp. 3. **Adequate documentation.** A nursing facility shall keep adequate documentation.

A. In order to be adequate, documentation must:

(1) Be maintained in orderly, well-organized files.

(2) Not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the department to the nursing facility's annual cost report.

(3) Include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or nursing facilities. If any of the information is not available, the nursing facility shall document its good faith attempt to obtain the information.

(4) Include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues.

(5) Be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in part 9549.0041, subpart 13, item A, the records are necessary to resolve a pending appeal, or are required for the enforcement of Minnesota Statutes, section 256B.48.

B. Compensation for personal services, regardless of whether treated as direct or indirect costs, must be documented on payroll records. Payrolls must be supported by time and attendance or equivalent records for individual employees. Salaries and wages of employees which are allocated to more than one cost category must be supported by time distribution records. The method used must produce a proportional distribution of actual time spent, or an accurate estimate of time spent performing assigned duties. The nursing facility that chooses to estimate time spent must use a statistically valid method. The compensation must reflect an amount proportionate to a full-time basis if the services are rendered on less than a full-time basis.

C. Except for vehicles used exclusively for nursing facility business, the nursing facility or related organization must maintain a motor vehicle log that shows nursing facility mileage for the reporting year. Mileage paid for the use of a personal vehicle must be documented.

D. Complete and orderly records must be maintained for cost allocations made to cost categories.

Subp. 4. **Compensation for personal services.** Compensation for personal services includes all the remuneration paid currently, accrued or deferred, for services rendered by

the nursing facility's owners or employees. Only compensation costs for the current reporting period are allowable subject to the requirements of parts 9549.0010 to 9549.0080.

A. Compensation includes:

(1) salaries, wages, bonuses, vested vacations, vested sick leave, and fringe benefits paid for managerial, administrative, professional, and other services;

(2) amounts paid by the nursing facility for the personal benefit of the owners or employees;

(3) the costs of assets and services which the owner or employee receives from the nursing facility;

(4) deferred compensation, individual retirement plans such as individual retirement accounts, pension plans, and profit-sharing plans;

(5) the annual cost of supplies, use of capital assets, services for personal use, or any other in kind benefits received by the owners or employees; and

(6) payment to organizations of nonpaid workers, that have arrangements with the nursing facility for the performance of services by the nonpaid workers.

B. The nursing facility must have a written policy for payment of compensation for personal services. The policy must relate the individual's compensation to the performance of specified duties and to the number of hours worked. Compensation payable under the plan must be consistent with the compensation paid to persons performing similar duties in the nursing facility industry. Employees covered by collective bargaining agreements are not required to be covered by the policy if the collective bargaining agreement otherwise meets the essentials of the policy required by this item.

C. Only necessary services shall be compensated.

D. Except for accrued vested vacation, accrued vested sick leave, or compensation claims subject to litigation or employer-employee dispute resolution, compensation must be actually paid, whether by cash or negotiable instrument, within 107 days after the close of the reporting period. If payment is not made within the 107 days, the unpaid compensation shall be disallowed in that reporting year.

Subp. 5. **Licensure and certification costs.** Subject to parts 9549.0010 to 9549.0080 all operating costs of meeting the licensure and certification standards in items A to C are allowable operating costs for the purpose of setting nursing facility payment rates. The standards are:

A. standards set by federal regulations for skilled nursing facilities and intermediate care facilities;

B. requirements established by the Minnesota Department of Health for meeting health standards as set out by state rules and federal regulations; and

C. other requirements for licensing under state and federal law, state rules, or federal regulations that must be met to provide nursing and boarding care services.

Subp. 6. **Routine service costs.** Subject to parts 9549.0010 to 9549.0080 all operating costs of routine services including nursing, dietary, and support services are allowable operating costs for the purpose of setting nursing facility payment rates.

Subp. 7. **Related organization costs.** Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization are includable in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, or capital assets, or supplies.

Subject to parts 9549.0010 to 9549.0080, the cost of ownership of a capital asset which is used by the nursing facility must be included in the allowable cost of the nursing facility even though it is owned by a related organization.

Subp. 8. **General cost principles.** For rate-setting purposes, a cost must satisfy the following criteria:

A. the cost is ordinary, necessary, and related to resident care;

B. the cost is what a prudent and cost conscious business person would pay for the specific good or service in the open market in an arm's length transaction;

C. the cost is for goods or services actually provided in the nursing facility;

D. the cost effects of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction shall prevail over form; and

E. costs that are incurred due to management inefficiency, unnecessary care or facilities, agreements not to compete, or activities not commonly accepted in the nursing facility care field are not allowable.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*

9549.0036 NONALLOWABLE COSTS.

The costs listed in items A to EE are not allowable for purposes of setting payment rates but must be identified on the nursing facility's cost report.

A. All contributions, including charitable contributions, and contributions to political action committees or campaigns.

B. Salaries and expenses of a lobbyist.

C. Legal and related expenses for unsuccessful challenges to decisions by governmental agencies.

D. Assessments made by or the portion of dues charged by associations or professional organizations for litigation except for successful challenges to decisions by agencies of the state of Minnesota; lobbying costs; or contributions to political action committees or campaigns. Where the breakdown of dues charged to a nursing facility is not provided, the entire cost shall be disallowed.

E. Advertising designed to encourage potential residents to select a particular nursing facility. This item does not apply to a total expenditure of $2,000 for all notices placed in the telephone yellow pages for the purpose of stating the nursing facility's name, location, phone number, and general information about services in the nursing facility.

F. Assessments levied by the commissioner of the Minnesota Department of Health for uncorrected violations.

G. Employee or owner's membership or other fees for social, fraternal, sports, health, or similar organizations.

H. Cost incurred for activities directly related to influencing employees with respect to unionization.

I. Costs of activities not related to resident care such as flowers or gifts for employees or owners, employee parties, and business meals except as in part 9549.0040, subpart 7, item X.

J. Costs related to purchase of and care for pets in excess of $5 per year per licensed bed.

K. Penalties including interest charged on the penalty, interest charges which result from an overpayment, and bank overdraft or late payment charges.

L. Costs of sponsoring employee, youth, or adult activities such as athletic teams and beauty contests.

M. Premiums on owner's or board member's life insurance policies, except that such premiums shall be allowed if the policy is included within a group policy provided for all employees, or if such a policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the beneficiary.

N. Personal expenses of owners and employees, such as vacations, boats, airplanes, personal travel or vehicles, and entertainment.

O. Costs of training programs for anyone other than employees or volunteers in the nursing facility.

P. Costs of training programs to meet the minimum educational requirements of a position, education that leads to a degree, or education that qualifies the employee for a new trade or profession. This item does not apply to training or education of nursing aides or training to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties.

Q. Bad debts and related bad debt collection fees except as provided in part 9549.0040, subpart 7, item V.

R. Costs of fund raising activities.

S. Costs associated with the management of investments which may produce interest income, dividend income, or other investment income or losses.

T. Costs of functions normally paid by charges to residents, employees, visitors, or others such as the direct and indirect costs of operating a pharmacy, congregate dining program, home delivered meals program, gift shop, coffee shop, apartment, or day care center.

U. Operating costs for activities to the extent that the activities are financed by gifts or grants from public funds. A transfer of funds from a local governmental unit to its governmentally owned nursing facility is not a gift or grant under this item.

V. Telephone, television, and radio service provided in a resident's room except as in part 9549.0040, subpart 6, item D.

W. Costs of covenants not to compete.

X. Identifiable costs of services provided by a licensed medical therapeutic or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis, including:

(1) the purchase of service fees paid to the vendor or his or her agent who is not an employee of the nursing facility or the compensation of the practitioner who is an employee of the nursing facility;

(2) allocated compensation and related costs of any nursing facility personnel assisting in providing these services; and

(3) allocated operating or property cost for providing these services such as housekeeping, laundry, maintenance, medical records, payroll taxes, space, utilities, equipment, supplies, bookkeeping, secretarial, insurance, supervision and administration, and real estate taxes and special assessments.

If any of the costs in subitems (1) to (3) are incurred by the nursing facility, these costs must be reported as nonreimbursable expenses, together with any of the income received or anticipated by the nursing facility including any charges by the nursing facility to the vendor.

Y. Costs for which adequate documentation is not maintained or provided as required by parts 9549.0010 to 9549.0080.

Z. Fringe benefits or payroll taxes associated with disallowed salary costs.

AA. Costs associated with sales or reorganizations of nursing facilities.

BB. Accruals of vacation and sick leave for employees which are not fully vested.

CC. Payments made in lieu of real estate taxes, unless such payments are made under a legally enforceable irrevocable written contract entered into prior to June 17, 1985.

DD. Adverse judgments, settlements, and repayments of escrow accounts resulting from the enforcement of Minnesota Statutes, section 256B.48 and related costs and expenses.

EE. Costs including legal fees, accounting fees, administrative costs, travel costs, and the costs of feasibility studies attributed to the negotiation or settlement of a sale or purchase of any capital asset by acquisition or merger for which any payment has previously been made under parts 9549.0010 to 9549.0080.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; 11 SR 866; L 1992 c 513 art 7 s 136*

9549.0040 REPORTING BY COST CATEGORY.

Subpart 1. **Dietary services.** The costs listed in items A to D are to be reported in the dietary services cost category:

A. direct costs of normal and special diet food including raw food, dietary supplies, food preparation and serving, and special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician;

B. the salaries and wages of the supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room including the salaries or fees of dietary consultants;

C. the costs of training including the cost of lodging and meals to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties; and

D. the costs of travel necessary for training programs for dietitians required to maintain licensure, certification, or professional standards.

Subp. 2. **Laundry and linen services.** The costs listed in items A and B are to be reported in the laundry and linen services cost category:

A. direct costs of linen and bedding, the laundering of resident clothing, other laundering, and laundry supplies; and

B. the salaries and wages of the supervisor, menders, ironers, and other laundry employees.

Subp. 3. **Housekeeping services.** The costs listed in items A and B are to be reported in the housekeeping services cost category:

A. direct costs of housekeeping supplies, including cleaning and lavatory supplies; and

B. the salaries and wages of the supervisor, housekeepers, and other cleaning personnel.

Subp. 4. **Plant operation and maintenance services.** The costs listed in items A to C are to be reported in the plant operations and maintenance cost category:

A. direct costs for maintenance and operation of the building and grounds, including fuel, electricity, water, sewer, supplies, tools, and repairs which are not capitalized;

B. the salaries and wages of the supervisor, engineers, heating-plant employees, independent contractors, and other maintenance personnel; and

C. the cost of required licenses and permits required for operation of the nursing facility.

Subp. 5. **Nursing services.** Direct costs associated with nursing services identified in items A to Y, are to be included in the nursing services cost category:

A. nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;

B. bedside care and services;

C. care and services according to the order of the attending physicians;

D. monitoring procedures such as vital signs, urine testing, weight, intake and output, and observation of the body system;

E. administration of oral, sublingual, rectal, and local medications topically applied, and appropriate recording of the resident's responses;

F. drawing blood and collecting specimens for submission to laboratories;

G. prevention of skin irritation and decubitus ulcers;

H. routine changing of dressings;

I. training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing facility;

J. supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;

K. care of residents with casts, braces, splints, and other appliances requiring nursing care or supervision;

L. care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;

M. administration of oxygen;

N. use of nebulizers;

O. maintenance care of resident's colostomy, ileostomy, and urostomy;

P. administration of parenteral medications, including intravenous solutions;

Q. administration of tube feedings;

R. nasopharyngeal aspiration required for maintenance of a clean airway;

S. care of suprapubic catheters and urethral catheters;

T. care of tracheostomy, gastrostomy, and other tubes in a body;

U. costs of equipment and supplies that are used to complement the services in the nursing services cost category, including items stocked at nursing stations or on the floor and distributed or used individually, including: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap and water, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents, and drugs which are not paid on a separate fee schedule by the medical assistance program or any other payer;

V. costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties, except that training to become a nurses aid is an allowable cost;

W. the salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants;

X. the salaries or fees of medical director, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and

Y. the costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.

Subp. 6. **Other care-related services.** The costs listed in items A to D are to be reported in the other care-related services cost category:

A. direct costs of other care-related services, such as recreational or religious activities, arts and crafts, pets, and social services which are not reimbursed separately on a fee for service basis;

B. the salaries and wages of recreational therapists and aides, rehabilitation therapists and aides, chaplains, arts and crafts instructors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately on a fee for service basis;

C. the costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties; and

D. telephone, television, and radio services provided in areas designated for use by the general resident population, such as lounges and recreation rooms and the charge of transferring a resident's phone from one room to another within the same nursing facility.

Subp. 7. **General and administrative services.** Direct costs for administering the overall activities of the nursing facility are included in the general and administrative cost category. These direct costs include:

A. business office functions;

B. travel expenses other than travel expenses reported under subparts 1, item D, and 5, item Y;

C. all motor vehicle operating expenses;

D. telephone and telegraph charges;

E. office supplies;

F. insurance, except as included as a fringe benefit;

G. personnel recruitment costs including help wanted advertising;

H. the salaries, wages, or fees of administrators, assistant administrators, accounting and clerical personnel, data processing personnel, and receptionists;

I. professional fees for services such as legal, accounting, and data processing services;

J. management fees, and the cost of management and administrative consultants;

K. central, affiliated, or corporate office costs excluding the cost of depreciable equipment used by individual nursing facilities which are included in the computation of the property-related payment rate under part 9549.0060 and those costs specified in part 9549.0030, subpart 4, items A and B;

L. business meetings and seminars;

M. postage;

N. training including the cost of lodging and meals for management personnel and personnel not related to direct resident care if the training either meets the requirements of laws, rules, or regulations to keep an employee's salary, status, or position or maintains or updates skills needed to perform the employee's present duties;

O. membership fees for associations and professional organizations which are directly related to resident care;

P. subscriptions to periodicals which are directly related to the operation of the nursing facility;

Q. security services or security personnel;

R. joint commission on accreditation of hospitals survey;

S. advertising;

T. board of director's fees;

U. interest on working capital debt;

V. bad debts and fees paid for collection of bad debts provided that the conditions in subitems (1) to (4) are met:

(1) the bad debt results from nonpayment of the payment rate or part of the payment rate;

(2) the nursing facility documents that reasonable collection efforts have been made, the debt was uncollectible, and there is no likelihood of future recovery;

(3) the collection fee does not exceed the amount of the bad debt; and

(4) the debt does not result from the nursing facility's failure to comply with federal and state laws, state rules, and federal regulations;

W. the portion of preopening costs capitalized as a deferred charge and amortized over a period of 120 consecutive months beginning with the month in which a resident first resides in a newly constructed nursing facility;

X. the cost of meals incurred as a result of required overnight business related travel; and

Y. any costs which cannot be specifically classified to another cost category.

Subp. 8. **Payroll taxes, fringe benefits, and clerical training.** Only the costs identified in items A to I are to be reported in the payroll taxes, fringe benefits, and clerical training cost category:

A. the employer's share of the social security withholding tax;

B. state and federal unemployment compensation taxes or costs;

C. group life insurance;

D. group health and dental insurance;

E. workers' compensation insurance;

F. either a pension plan or profit-sharing plan, approved by the United States Internal Revenue Service, but not both for the same employee;

G. governmentally required retirement contributions;

H. uniform allowance; and

I. costs of training clerical personnel including the cost of meals and lodging.

Subp. 9. **Real estate taxes and special assessments.** Real estate taxes and special assessments for each nursing facility are to be reported in the real estate taxes and special assessments cost category. In addition, payments permitted under part 9549.0036, item CC must be reported in this cost category.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*

9549.0041 GENERAL REPORTING REQUIREMENTS.

Subpart 1. **Required cost reports.** No later than December 31 of each year, the nursing facility shall submit an annual cost report for the reporting year ending September 30 on forms supplied by the commissioner in order to receive medical assistance program payments. In addition, the nursing facility shall obtain an annual audit of its financial records

from an independent certified public accountant or licensed public accountant. The examination must be conducted in accordance with generally accepted auditing standards as adopted by the American Institute of Certified Public Accountants and generally accepted accounting principles. A governmentally owned nursing facility may comply with these auditing requirements by submitting the audit report prepared by the state auditor.

Subp. 2. **Required information.** A complete annual report must include the following items.

A. General nursing facility information and statistical data as requested on the cost report form.

B. Reports of historical costs with supporting calculations, worksheets, and an explanation of the historical costs as requested on the cost report form.

C. A complete statement of fees and charges, including the rate or rates charged to private paying residents, as audited by a certified or licensed public accountant as defined by Minnesota Statutes, section 412.222 for the fiscal year of the nursing facility.

D. A copy of the nursing facility's audited financial statements for its fiscal year ending during the reporting year. The audited financial statements must include a balance sheet, income statement, statement of retained earnings, statement of changes in financial position (cash and working capital methods), appropriate notes to the financial statements, any applicable supplemental information, and the certified or licensed public accountant's opinion. If the financial statements are not sufficiently detailed or the nursing facility's fiscal year is different from the reporting year, the nursing facility shall provide supplemental information that reconciles costs on the financial statements with the cost report.

E. A statement of ownership for the nursing facility, including the name, address, and proportion of ownership of each owner.

If a privately held or closely held corporation or partnership has an ownership interest in the nursing facility, the nursing facility must report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed for reimbursement in the nursing facility's cost report must be identified regardless of the proportion of ownership interest.

If a publicly held corporation has an ownership interest of 15 percent or more in the nursing facility, the nursing facility must report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of ten percent or more.

F. Copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility if not previously submitted.

G. A listing of nursing facility debt outstanding during the reporting year, and the name of the lender, the term of debt, interest rate of debt, interest and principal payments for the current year and all remaining years, and the original amount of debt and any portion of debt as required by part 9549.0060, subpart 5.

H. An explanation of all adjustments to the historical costs.

I. The nursing facility's statement of property tax payable according to subpart 5.

Subp. 3. **Information which may be required.** In addition to the reports required in subpart 2, the commissioner may require the following:

A. Access to certified and licensed public accountant's audit workpapers which support the audited financial statements and cost reports.

B. Separate audited financial statements that correspond to the fiscal year ended during the reporting year for any other Minnesota nursing facility owned in whole or part by the same owners.

C. Separate audited financial statements which correspond to the fiscal year ended during the reporting year for any related organization doing business with the nursing facility if the related organization has not previously had an audited financial statement. At the commissioner's request, the related organization shall provide audited financial statements within 90 days after the end of the related organization's fiscal year in which the request is made.

D. Copies of leases, purchase agreements, or other documents related to the purchase or acquisition of equipment, goods, and services which are claimed as allowable costs.

E. Access to federal and state income tax returns for the nursing facility, related organization, and any individual or corporation having an ownership interest in the nursing facility as specified in subpart 2, item E.

F. Other relevant information necessary to support a payment request.

Subp. 4. **Additional information required from hospital-attached nursing facilities.** In addition to the reports required in subparts 2 and 3, hospital-attached nursing facilities shall provide a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year. If the Medicare cost report covers a period other than the nursing facility's reporting year, the nursing facility shall provide a copy of the Medicare cost report prepared using costs for the nursing facility's reporting period in addition to supplemental information which reconciles costs on the financial statements with the reporting period costs. The nursing facility must provide individual stepdowns for each cost category in part 9549.0040. The individual stepdowns must be prepared in accordance with instructions provided by the commissioner.

Subp. 5. **Reporting real estate taxes and special assessments.** The nursing facility shall submit a copy of its statement of property tax payable for the calendar year in which the rate year begins by April 5 of that calendar year. Except as provided in this subpart, the commissioner shall disallow the costs of real estate taxes if the documentation is not submitted by April 5. The disallowance shall remain in effect until the nursing facility provides the documentation and amends the cost report under subpart 14. If the county has not provided to the nursing facility a statement of property tax payable by April 5, the commissioner shall use the property tax payable during the previous reporting year until the statement is received by the department. Upon receipt of the statement of property tax payable, the commissioner shall adjust the payment rate accordingly. Special assessments and related interest paid during the reporting year must be shown on the cost report.

Subp. 6. **Method of accounting.** The accrual method of accounting in accordance with generally accepted accounting principles is the only method acceptable for purposes of satisfying reporting requirements. If a governmentally owned nursing facility demonstrates that the accrual method of accounting is not applicable to its accounts and that a cash or modified accrual method of accounting more accurately reports the nursing facility's financial operations, the commissioner shall permit the governmentally owned nursing facility to use a cash or modified accrual method of accounting.

Subp. 7. **Records.** The nursing facility shall maintain statistical and accounting records in sufficient detail to support information contained in the nursing facility's cost reports and audited statement for at least five years including the year following submission of an annual cost report.

Subp. 8. **Conflicts.** If conflicts occur between parts 9549.0010 to 9549.0080 and generally accepted accounting principles, parts 9549.0010 to 9549.0080 shall prevail.

Subp. 9. **Certification of reports.** Reports required in this part must be accompanied by a certification of the person having over 50 percent effective ownership or the chief financial officer if there is no majority owner, and the administrator or chief operating executive. If reports have been prepared by a person other than these individuals, a separate statement signed by the preparer must accompany the report.

Subp. 10. **Deadlines and extensions.** The deadline for submission of reports and the extension of the deadline is governed by items A to C.

A. The nursing facility shall submit the required annual cost report to the commissioner by December 31. The annual cost report must cover the reporting year ending on September 30 of that year.

B. The commissioner may reject any annual cost report filed by a nursing facility that is incomplete or inaccurate or may require additional information necessary to support the payment rate request. The corrected report or the additional information requested must be returned to the commissioner within 20 days of the request or the report must be rejected. The commissioner may extend this time if the nursing facility makes a showing of good cause in writing and if the commissioner determines that the delay in receipt of the information will not prevent the commissioner from establishing rates in a timely manner as required by law. Failure to file the required cost report and other required information or to correct the form of an incomplete or inaccurate report shall result in its rejection and in a reduction of the payment rate in subpart 12. The failure to provide additional information shall also result in a reduction of the payment rate in subpart 12 unless the total payment rate can be calculated by the disallowance of the cost for which additional information was requested, in which case no rate reduction as specified in subpart 12 shall occur.

C. The commissioner may grant one 15-day extension of the reporting deadline. To receive an extension, a nursing facility must submit a written request by December 1. The commissioner must notify the nursing facility of the decision to grant or deny an extension by December 15.

Subp. 11. **Effective date of total payment rate.** The commissioner shall provide to all nursing facilities notice of the total payment rate by May 1 of each year. The total payment rate is effective from July 1 of that year to June 30 of the following year.

Subp. 12. **Noncompliance.** A nursing facility's failure to comply with reporting requirements subjects the nursing facility to items A to C.

A. If a nursing facility fails to provide reports, documentation, and worksheets required in this part, the commissioner shall reduce the nursing facility's total payment rate to 80 percent of the total payment rate as provided in item B.

B. The reduced total payment rate is effective:

(1) 21 days after a written request for additional information under subpart 3, items A to D, is sent by the commissioner or at the expiration of any additional time period the commissioner may allow under subpart 10, item B.

(2) For failure to provide the information required in subpart 1, 2, 4, or 9. On January 1, if no extension has been granted; on January 15, if the extension was granted; or 21 days after a written request for the correction or completion of inaccurate reports of financial statements, or at the expiration of a further time period that the commissioner allows under subpart 10, item B.

C. Reinstatement of the total payment rate upon remedy of the failure or inadequacy is not retroactive.

Subp. 13. **Audits.** Nursing facility audits are subject to items A to D.

A. The department shall subject all reports and supporting documentation to desk and field audits to determine compliance with parts 9549.0010 to 9549.0080. Retroactive adjustments may be made as a result of desk or field audit findings. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

B. Field audits may cover the four most recent annual cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's cost report. All transactions, invoices, or other documentation that support or relate to the costs claimed on the annual cost reports

are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the cost report within the time period specified by the commissioner, the commissioner may calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided or apply the penalty in subpart 12, item A, whichever would result in the least amount of change in the total payment rate.

C. Changes in the total payment rate which result from desk or field audit adjustments to cost reports for reporting years beyond the four most recent annual cost reports must be made to the four most recent annual cost reports, the current cost report, and future cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

D. The commissioner may extend the period for retention of records under part 9549.0035, subpart 3, item A, subitem (5) for purposes of performing field audits as necessary to enforce Minnesota Statutes, section 256B.48.

Subp. 14. **Amended reports.** Amendments to previously filed annual cost reports are governed by items A and B.

A. Nursing facilities may file amendments to previously filed annual cost reports when:

(1) Errors or omissions in the annual cost report are discovered and an amendment would result in at least a five-cent per resident day or $2,000 adjustment, whichever is less for each reporting year. The commissioner shall make retroactive adjustments to the total payment rate of an individual nursing facility if the amendment is filed within 14 months of the original cost report to be amended. An error or omission for purposes of this item does not include a nursing facility's determination that a prior election between alternative methods of reporting costs permitted under parts 9549.0010 to 9549.0080 was not advantageous and should be changed. Errors or omissions that do not meet the threshold amount required for amended cost reports, or errors or omissions discovered after the 14-month time limitation specified in this item, may be claimed at the time of the field audit.

(2) A nursing facility which qualifies for a special reappraisal under part 9549.0060, subpart 3 to adjust its property related payment rate.

B. Nursing facilities must not amend a previously filed cost report for the purpose of removing costs of services for which the nursing facility seeks separate billing.

Subp. 15. **False reports.** If a nursing facility knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

A. immediately adjust the nursing facility's payment rate to recover the entire overpayment within the rate year;

B. terminate the commissioner's agreement with the nursing facility;

C. prosecute under applicable state or federal law; or

D. use any combination of items A, B, and C.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; 11 SR 866; L 1992 c 513 art 7 s 136*

9549.0050 SCOPE.

Parts 9549.0050 to 9549.0059 establish procedures for determining the operating cost payment rates for all nursing facilities 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; 256B.431*

History: *11 SR 1990; L 1992 c 513 art 7 s 136*

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 facility 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 facility unless the transfer is to a different licensure level; or

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

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 facilities means the comprehensive care plan as set forth in Code of Federal Regulations, title 42, section 483.20, paragraph (d), as amended through October 1, 1992.

Subp. 13. **Short length of stay facility.** "Short length of stay facility" means a nursing facility 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 facility by dividing actual resident days in the skilled level of care for which the nursing facility 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 facility 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; 256B.431*

History: *11 SR 1990; L 1992 c 513 art 7 s 136; 18 SR 2584*

9549.0052 ESTABLISHMENT OF GEOGRAPHIC GROUPS.

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

Subp. 2. **Group 1.** All nursing facilities 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 facilities 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 facilities 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; 256B.431*

History: *11 SR 1990; L 1992 c 513 art 7 s 136*

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 facility'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 facility'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 facility 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 facilities 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 facility'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 facility under this item.

(4) If a nursing facility'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 facility in that operating cost category are not performed by a related organization, the nursing facility 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 facility separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing facility 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 facilities that separately reported food costs. The nursing facility's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing facility.

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 facility 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 facility 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 facilities that separately reported dietitian consulting fees. The nursing facility's total number of licensed beds must be multiplied by the average cost per bed to determine the dietitian consulting fees for the nursing facility.

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136*

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 facility during the reporting year preceding the rate year to determine the nursing facility'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 facility's standardized resident days must be determined in accordance with items A to C.

A. The nursing facility'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 facility's standardized resident days for the reporting year.

C. For the rate year beginning July 1, 1987, only, the nursing facility'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 facility'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 facility's reporting year.

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136*

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 facility licensed on June 1, 1983, by the commissioner to provide residential services for persons with physical disabilities 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 facility'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 facility property and coverage against loss or damage to the

building, building contents, and the property of others on the premises of the nursing facility 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 facilities, short length of stay facilities, and nursing facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing facilities 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 facility 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 facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled 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 facilities 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 facility 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 commodities 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; 256B.431*

History: *11 SR 1990; L 1992 c 513 art 7 s 136; L 2005 c 56 s 2*

9549.0056 DETERMINATION OF OPERATING COST PAYMENT RATE.

Subpart 1. **Nonadjusted case mix and other care related payment rate.** For each nursing facility, 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 facility'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 facility'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 facility'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 facility, 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 facility 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 facility'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 facility'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 facility'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 facility'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 facility licensed on June 1, 1983, by the commissioner to provide residential services for persons with physical disabilities 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 facility'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 facility'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 facility'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 facility 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 facility'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 facility'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 facility or portion of the nursing facility for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing facility 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 facility 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 facility cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing facility 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 facility will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing facility 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 facility under item B to determine if the nursing facility meets the criteria in subitems (1) to (5).

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

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

(3) The nursing facility 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 facility 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 facility'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 facility'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 facility'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 facility's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing facility's nursing cost per hour must be determined by dividing the nursing facility's total allowable historical case mix operating costs by the nursing facility'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 facility'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 facility'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 facility'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 facility'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 facility provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing facility 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 facility 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 facility under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing facility 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 facility's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing facility's total payment rate shall continue to be paid to the nursing facility 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 facility's total payment rate shall continue to be paid to the nursing facility at the same level until June 30, 1988.

F. The nursing facility must record the costs associated with this subpart separately from other nursing facility costs until the commissioner's fiscal and compliance review under item E establishes that the nursing facility 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 facility rate limits shall be phased in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136; L 2005 c 56 s 2*

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

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing facility 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 facility, 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 facility 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 facility'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 facility'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 facility 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; 256B.431*

History: *11 SR 1990; L 1992 c 513 art 7 s 136*

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; 256B.431*

History: *11 SR 1990*

9549.0059 RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility 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 facility applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.0911, 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.0911, 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 facility 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 facility 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 facility must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.0911, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.0911. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing facility that is licensed differently than the section the resident previously was placed in or a resident who has been transferred from another nursing facility.

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 facility.

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 facility must be assessed by the nursing facility. The nursing facility 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 facility 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 facility.

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care or interagency transfer form must be submitted to the Department of Health by the nursing facility 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 facility.

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

A. A nursing facility 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 Physician's Statement of General Condition (item 10), Individual Dependencies (items 21 to 24 and 28), Medications (items 31 to 34), and Primary, Secondary, and Tertiary Diagnoses (on the back of the form) do not require completion. The registered nurse performing the assessment shall sign the assessment form on the day the assessment is completed.

C. Within five working days of the completion of the nursing facility's semiannual resident assessments, the nursing facility 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 and the nursing facility'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 facility 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. QA&R shall not establish classifications for residents who experience an admission, transfer, hospital return, or discharge occurring during the QA&R team visit.

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

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

B. In addition to the assessment required in item A, residents who have returned to the same nursing facility after hospital admission must be reassessed by the nursing facility no less than 30 days and no more than 35 days after return from the hospital unless

the nursing facility'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 facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of care or interagency transfer form. Upon request, the nursing facility 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 facility 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 facility 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 facility 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 facility 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 facility resident or the resident's authorized representative according to items A to D.

A. The nursing facility 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 facility. The nursing facility must include a notice that the nursing facility has chosen to appeal the rates under part 9549.0080.

B. The nursing facility 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 facility must provide each nursing facility 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 facility must include the current rate for the new classification with the classification letter.

D. The nursing facility must provide each nursing facility 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; 256B.431*

History: *11 SR 1990; L 1987 c 309 s 24; 13 SR 130; 16 SR 93; L 1992 c 513 art 7 s 136; 18 SR 2584*

9549.0060 DETERMINATION OF THE PROPERTY RELATED PAYMENT RATE.

Subpart 1. **Initial appraised value.** For the rate year beginning July 1, 1985, the commissioner shall contract with a property appraisal firm which shall use the depreciated replacement cost method to determine the appraised value of each nursing facility participating in the medical assistance program as of June 30, 1985. The initial appraised value of each nursing facility and any subsequent reappraisal under subparts 2 and 3 must be limited to the value of buildings, attached fixtures, and land improvements used by the nursing facility and must be subject to the limits in subpart 4.

For hospital attached nursing facilities, the commissioner shall require the appraisal of those portions of buildings, attached fixtures, and land improvements in service areas shared between the nursing facility and the hospital. The appraised value of the shared service areas must be allocated between the nursing facility and the hospital or other nonnursing home areas using the Medicare worksheet B-1 statistics in effect on September 30, 1984. The appraised value of the shared service areas must be allocated by stepdown placing the appraised values on the appropriate line of column 1 on the Medicare worksheet B. The appraised value of the shared service areas allocated to the nursing facility shall be added to the appraised value of the nursing facility's buildings, attached fixtures, and land improvements.

For a newly constructed nursing facility applying to participate in the medical assistance program which commenced construction after June 30, 1985, or a nursing facility with an increase in licensed beds of 50 percent or more, the commissioner shall require an initial appraisal upon completion of the construction. The construction is considered complete upon issuance of a certificate of occupancy or, if no certification of occupancy is required, when available for resident use. The property related payment rate is effective on the earlier of either the first day a resident is admitted or on the date the nursing facility is certified for medical assistance.

Subp. 2. **Routine updating of appraised value.** For rate years beginning after June 30, 1986, the commissioner shall routinely update the appraised value according to items A to C.

A. The commissioner shall contract with a property appraisal firm which shall use the depreciated replacement cost method to perform reappraisals. Each calendar year, the commissioner shall select a random sample of not less than 15 percent of the total number of nursing facilities participating in the medical assistance program as of July 1 of that year. The sample must not include nursing facilities receiving an interim payment rate under subpart 14. All nursing facilities in the sample must be reappraised during the last six months of the calendar year. Incomplete additions or replacements must not be included in the reappraisals. An incomplete addition or replacement is one for which a certificate of occupancy is not yet issued, or if a certificate of occupancy is not required, the addition or replacement is not available for use.

The updated appraised value for hospital attached nursing facilities resulting from a reappraisal of shared service areas must be allocated to the nursing facility in the same ratio indicated by the Medicare stepdown in effect on September 30 of the rate year in

which the reappraisal is conducted. The method described in subpart 1, is to be used to determine allocation of the updated appraised value. The reappraised value of the shared service areas allocated to the nursing facility must be added to the reappraised value of the nursing facility's buildings, attached fixtures, and land improvements.

B. The commissioner shall compute the average percentage change in appraised values for the nursing facilities in the sample. The appraised value of each nursing facility not in the sample, and not reappraised under subpart 3, must be increased or decreased by the average percentage change subject to the limits in subpart 4. No redetermination of the average percentage change in appraised values shall be made as a result of changes in the appraised value of individual nursing facilities in the sample made after the commissioner's computation of the average percentage change.

C. For hospital attached nursing facilities not in the sample, the allocation of the appraised value of the shared service areas must be recomputed if the hospital involved experiences a cumulative change in total patient days as defined by the Medicare program of more than 15 percent from the reporting year in which the most recently used set of allocation statistics were determined. The allocation using the method described in subpart 1 must be based on the Medicare stepdown in effect on September 30 of the rate year in which the updating of the appraised value is performed.

D. The adjustment to the property related payment rate which results from updating the appraised value is effective for the rate year immediately following the rate year in which the updating takes place except as provided in subpart 14.

E. Each calendar year that a random sample is selected in item A to compute the average percentage change in appraised values in item B, the commissioner shall evaluate the adequacy of the sample size according to subitems (1) to (6).

(1) The tolerance level for an acceptable error rate must be plus or minus three percentage points.

(2) The confidence level for evaluating the sample size must be 95 percent.

(3) The sample size required to be within the tolerance level in subitem (1) must be computed using standard statistical methods for determination of a sample size.

(4) If the required sample size in subitem (3) is greater than the sample size used in item A, additional appraisals must be performed until the number of appraisals is equal to the required sample size in subitem (3). The additional nursing facilities needed to complete the required sample size must be randomly selected. A nursing facility that received a special reappraisal under subpart 3, or one that is receiving an interim payment rate under subpart 14, or one that was appraised in the original sample in item A must be excluded. The average percentage change in appraised values in item B must be recomputed based on the increased sample size in subitem (3).

(5) If the tolerance level in subitem (1) continues to be exceeded after applying the procedures in subitems (3) and (4), the procedures in subitems (3) and (4) must be repeated until the error rate is within the tolerance level.

(6) If the required sample size in subitem (3) is equal to or less than the sample size used in item A, the average percentage change in appraised values must be the percentage determined in item B.

Subp. 3. **Special reappraisals.** Special reappraisals are subject to the requirements of items A to F.

A. A nursing facility which makes an addition to or replacement of buildings, attached fixtures, or land improvements may request the commissioner to conduct a reappraisal upon project completion.

Upon receipt of a written request, the commissioner shall conduct a reappraisal within 60 days provided that all conditions of this subpart are met. The total historical cost of the addition or replacement, exclusive of the proceeds from disposals of capital assets or applicable credits such as public grants and insurance proceeds, must exceed the lesser of

$200,000 or ten percent of the most recent appraised value determined under subparts 1 to 4. The addition or replacement must be complete and a certificate of occupancy issued, or if a certificate of occupancy is not required, the addition or replacement must be available for use. Special reappraisals under this item are limited to one per 12-month period.

B. A nursing facility which retires buildings, attached fixtures, land improvements, or portions thereof without replacement, shall report the deletion to the commissioner within 30 days if the historical cost of the deletion exceeds $200,000. The commissioner shall conduct a reappraisal of the nursing facility to establish the new appraised value and adjust the property related payment rate accordingly.

C. The adjusted property related payment rate computed as a result of reappraisals in items A and B is effective on the first day of the month following the month in which the addition or replacement was completed or when the deletion occurred.

D. The commissioner shall reappraise every nursing facility at least once every seven calendar years following the initial appraisal. The commissioner shall reappraise a nursing facility if at the end of seven calendar years the nursing facility has not been reappraised at least once under subpart 2 or 3. The commissioner shall adjust the property related payment rate to reflect the change in appraised value. The adjustment of the property related payment rate is effective on the first day of the rate year immediately following the reappraisal.

E. The commissioner may require the reappraisal of a nursing facility within 60 days of receipt of information provided by the Minnesota Department of Health regarding the violation of standards and rules relating to the condition of capital assets.

F. Changes in appraised value computed in this subpart must not be used to compute the average percentage change in subpart 2, item B.

Subp. 4. **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to C.

A. For rate years beginning after June 30, 1985, the replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) Effective January 1, 1984, the replacement cost new per bed limit for licensed beds in single bedrooms is $41,251 and for licensed beds in multiple bedrooms is $27,500. On January 1, 1985, the commissioner shall adjust the replacement cost new per bed limit by the percentage change in the composite cost of construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers. The index is incorporated by reference and is available at the James J. Hill Reference Library, Saint Paul, Minnesota.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in subpart 10, item A and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1985.

(4) On January 1, 1986, and each succeeding January 1, the commissioner shall adjust the limit in subitem (3) by the percentage change in the composite cost of construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers.

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in subpart 11, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in subparts 1 to 3 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under parts 9549.0010 to 9549.0080.

D. The adjusted replacement cost new is the lesser of item B or C.

E. The adjusted depreciation is determined by subtracting from the depreciation in subparts 1 to 3 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in subparts 1 to 3.

Subp. 5. **Allowable debt.** For purposes of determining the property related payment rate, the commissioner shall allow or disallow debt according to items A to D.

A. Debt shall be limited as follows:

(1) Debt incurred for the purchase of land directly used for resident care and the purchase or construction of nursing facility buildings, attached fixtures, or land improvements or the capitalized replacement or capitalized repair of existing buildings, attached fixtures, or land improvements shall be allowed. Debt incurred for any other purpose shall not be allowed.

(2) Working capital debt shall not be allowed.

(3) An increase in the amount of a debt as a result of refinancing of capital assets which occurs after May 22, 1983, shall not be allowed except to the extent that the increase in debt is the result of refinancing costs such as points, loan origination fees, or title searches.

(4) An increase in the amount of total outstanding debt incurred after May 22, 1983, as a result of a change in ownership or reorganization of provider entities, shall not be allowed and the previous owner's allowable debt as of May 22, 1983, shall be allowed under item B.

(5) Any portion of the total allowable debt exceeding the appraised value as determined in subpart 4 shall not be allowed.

(6) Any portion of a debt of which the proceeds exceed the historical cost of the capital asset acquired shall not be allowed.

B. The nursing facility shall apportion debts incurred before October 1, 1984, among land and buildings, attached fixtures, land improvements, depreciable equipment and working capital by direct identification. If direct identification of any part of the debt is not possible, that portion of the debt which cannot be directly identified shall be apportioned to each component, except working capital debt, based on the ratio of the historical cost of the component to the total historical cost of all components. The portion of debt assigned to land and buildings, attached fixtures, and land improvements is allowable debt.

A hospital attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed

according to subpart 5, and allowable interest expense computed according to subpart 7 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in subpart 1.

C. For debts incurred after September 30, 1984, the nursing facility shall directly identify the proceeds of the debt associated with specific land and buildings, attached fixtures, and land improvements, and keep records that separate such debt proceeds from all other debt. Only the debt identified with specific land and buildings, attached fixtures, and land improvement shall be allowed.

D. For reporting years ending on or after September 30, 1984, the total amount of allowable debt shall be the sum of all allowable debts at the beginning of the reporting year plus all allowable debts at the end of the reporting year divided by two. Nursing facilities which have a debt with a zero balance at the beginning or end of the reporting year must use a monthly average for the reporting year.

E. Debt incurred as a result of loans between related organizations must not be allowed.

Subp. 6. **Limitations on interest rates.** The commissioner shall limit interest rates according to items A to C.

A. Except as provided in item B, the effective interest rate of each allowable debt, including points, financing charges, and amortization bond premiums or discounts, entered into after September 30, 1984, is limited to the lesser of:

(1) the effective interest rate on the debt; or

(2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under subpart 5, item D.

C. For rate years beginning on July 1, 1985, and July 1, 1986, the effective interest rate for debts incurred before October 1, 1984, is allowed if the interest rate is not in excess of what the borrower would have had to pay in an arms length transaction in the market in which the debt was incurred. For rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

Subp. 7. **Allowable interest expense.** The commissioner shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under subpart 5 and within the interest rate limits in subpart 6.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or replacement of those capital assets. For purposes of this item and part 9549.0035, subpart 2, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

C. Construction period interest expense must be capitalized as a part of the cost of the building. The period of construction extends to the earlier of either the first day a resident is admitted to the nursing facility, or the date the nursing facility is certified to receive medical assistance recipients.

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in subparts 1 to 4.

E. Increases in interest expense after May 22, 1983, which are the result of changes in ownership or reorganization of provider entities, are not allowable.

F. Except as provided in item G, increases in total interest expense which are the result of refinancing of debt after May 22, 1983, are not allowed. The total interest expense must be computed as the sum of the annual interest expense over the remaining term of the debt refinanced.

G. Increases in total interest expense which result from refinancing a balloon payment on allowable debt after May 22, 1983, shall be allowed according to subitems (1) to (3).

(1) The interest rate on the refinanced debt shall be limited under subpart 6, item A.

(2) The refinanced debt shall not exceed the balloon payment.

(3) The term of the refinanced debt must not exceed the term of the original debt computed as though the balloon payment did not exist.

Subp. 8. **Building capital allowance for owner operated nursing facilities or nursing facilities with capital leases.** Except as provided in subpart 14, for the rate years beginning after June 30, 1985, the building capital allowance for owner operated nursing facilities or nursing facilities with capital leases must be computed as follows:

A. The rental factor is 5.33 percent.

B. The difference between the nursing facility's allowable appraised value determined under subparts 1 to 4 and the allowable debt determined in subpart 5 is multiplied by the rental factor.

C. The amount determined in item B must be added to the total allowable interest expense determined under subparts 6 and 7.

D. Except as in item E, the amount determined in item C must be divided by 96 percent of capacity days.

E. If the average length of stay in the skilled level of care within a nursing facility is 180 days or less, the nursing facility shall divide the amount in item C by the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 96 percent of capacity days.

For purposes of this item, the nursing facility shall compute its average length of stay for the skilled level of care by dividing the nursing facility's skilled resident days for the reporting year by the nursing facility's total skilled level of care discharges for that reporting year.

Subp. 9. **Building capital allowance for nursing facilities with operating leases.** Except as provided in subpart 14, for rate years beginning after June 30, 1985, the building capital allowance for nursing facilities with operating lease costs incurred for buildings must be paid as determined by items A to C.

A. The allowable appraised value of the nursing facility must be established according to subparts 1 to 4.

B. The allowable interest expense determined under subparts 6 and 7 and the allowable debt determined under subpart 5 for the leased nursing facility must be considered zero.

C. Except as in item D, the building capital allowance must be the lesser of the operating lease expense divided by 96 percent of capacity days, or the allowable appraised value multiplied by the rental factor and then divided by 96 percent of capacity days.

D. A nursing facility with an average length of stay of 180 days or less as defined in subpart 8, item E, shall use the divisor determined in subpart 8, item E, instead of 96 percent of capacity days.

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 facility;

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

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

A nursing facility 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.

Subp. 10. **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

A. The historical cost of depreciable equipment for nursing facilities which do not have costs for operating leases for depreciable equipment in excess of $10,000 during the reporting year ending September 30, 1984, is determined under subitem (1) or (2).

(1) The total historical cost of depreciable equipment reported on the nursing facility's audited financial statement for the reporting year ending September 30, 1984, must be multiplied by 70 percent. The product is the historical cost of depreciable equipment.

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility.

For purposes of this item, a hospital attached nursing facility shall use the allocation method in subpart 1 to stepdown the historical cost of depreciable equipment.

B. The historical cost per bed of depreciable equipment for each nursing facility must be computed by dividing the total historical cost of depreciable equipment determined in item A by the nursing facility's total number of licensed beds on September 30, 1984.

C. All nursing facilities must be grouped in one of the following:

(1) nursing facilities with total licensed beds of less than 61 beds;

(2) nursing facilities with total licensed beds of more than 60 beds and less than 101 beds; or

(3) nursing facilities with more than 100 total licensed beds.

D. Within each group determined in item C, the historical cost per bed for each nursing facility determined in item B must be ranked and the median historical cost per bed established.

E. The median historical cost per bed for each group in item C as determined in item D must be increased by ten percent. For rate years beginning after June 30, 1986, this amount shall be adjusted annually by the percentage change indicated by the urban consumer price index for Minneapolis-Saint Paul, as published by the Bureau of Labor Statistics, new series index (1967=100) for the two previous Decembers. This index is incorporated by reference and available at the James J. Hill Reference Library, Saint Paul, Minnesota.

F. The equipment allowance for each group in item C shall be the amount computed in item E multiplied by 15 percent and divided by 350.

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

A. The number of capacity days is determined by multiplying the number of licensed beds in the nursing facility by the number of days in the nursing facility's reporting period.

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period.

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

(1) The nursing facility shall agree not to request a private room payment in part 9549.0070, subpart 3 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in subpart 4.

(3) The nursing facility 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 facility'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 facility's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing facility's reporting year.

(b) The nursing facility'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 facility'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 facility's single bedroom payment rates.

Subp. 12. **Capitalization.** For rate years after June 30, 1985, the cost of purchasing or repairing capital assets shall be capitalized under items A to D.

A. The cost of purchasing a capital asset listed in the depreciation guidelines must be capitalized. The cost of purchasing any other capital asset not included in the depreciation guidelines must be capitalized if the asset has a useful life of more than two years and costs more than $500.

B. The nursing facility may consider as an expense a repair that costs $500 or less. Repairs that are considered as an expense must be classified in the plant operation and maintenance cost category. If the cost of a repair to a capital asset is $500 or more, and the estimated useful life of the capital asset is extended beyond its original estimated useful life by at least two years, or if the productivity of the capital asset is increased significantly over its original productivity, then the cost of the repair must be capitalized.

C. The property related expenditures related to capital assets such as lease or depreciation, interest, and real estate taxes which are used by central, affiliated, or corporate offices must be classified in the nursing facility's general and administrative cost category.

D. Construction period interest expense, feasibility studies, and other costs related to the construction period must be capitalized.

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

A. Except as provided in subpart 14, the building capital allowance of each nursing facility shall be added to the equipment allowance.

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

(1) For the rate year beginning July 1, 1985, the nursing facility's historical property related per diem shall be determined by adding the allowable historical property related costs used to compute the property related payment rate effective on June 30, 1985, and dividing the sum by 96 percent capacity days. A nursing facility with an average length of stay of 180 days or less as defined in subpart 8, item E, shall use the divisor determined in subpart 8, item E, instead of 96 percent of capacity days.

(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 facility's capacity days change. If the nursing facility's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing facility 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.

C. For rate years beginning after June 30, 1985, the property related payment rate shall be the lesser of the amount computed in item A or the historical property related per diem in item B increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except as provided in items D to G.

D. A nursing facility whose allowable historical property related per diem determined in item B is less than or equal to $2.25 shall receive a property related payment rate equal to the greater of $2.25 or its allowable historical property related per diem increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except that the property related payment rate shall not exceed the amount determined in item A.

E. A nursing facility whose allowable historical property related per diem determined in item B is greater than the amount determined in item A shall receive a property related payment rate equal to its allowable historical property related per diem.

F. In the event of a change of ownership or reorganization of the provider entity occurring after June 30, 1985, the nursing facility's property related payment rate must be the lesser of the property related payment rate in effect at the time of sale or reorganization or the amount determined in item A. Changes in the property related payment rate as a result of this item shall be effective on the date of the sale or reorganization of the provider entity.

G. The property related payment rate for a nursing facility which qualifies for the special reappraisal in subpart 3, item A shall be determined according to subitems (1) and (2).

(1) If the amount computed according to item A using the reappraised value is equal to or less than the property related payment rate in effect prior to the reappraisal, the property related payment rate in effect prior to the reappraisal shall not be adjusted.

(2) If the amount computed according to item A using the reappraised value is greater than the property related payment rate in effect prior to the reappraisal, the property related payment in effect prior to the reappraisal shall be added to the difference between the amount computed according to item A using the reappraised value and the amount computed according to item A using the most recent appraised value prior to the reappraisal. This sum must not exceed the amount computed in item A using the reappraised value. If the difference between the amount computed according to item A using the reappraised value and the amount computed according to item A using the most recent appraised value prior to the reappraisal is equal to or less than zero, the difference shall be considered zero.

H. For rate years beginning after June 30, 1990, the property related payment rate shall be the sum of the building capital allowance and the equipment allowance.

Subp. 14. **Determination of interim and settle up payment rates.** The commissioner shall determine interim and settle up payment rates according to items A to J.

A. A newly constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the commissioner to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in parts 9549.0010 to 9549.0080 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with parts 9549.0010 to 9549.0080. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined by 12 MCAR S 2.05014 [Temporary] except that capital assets must be classified under parts 9549.0010 to 9549.0080.

D. The interim property related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed and upon receipt of written application from the nursing facility, the commissioner shall establish the nursing facility's appraised value according to subparts 1 and 4.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to subparts 5 and 7.

(3) The interim building capital allowance must be determined under subpart 8 or 9.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with subpart 10 which is in effect on the effective date of the interim property related payment rate.

(5) The interim property related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle up property related payment rate and the property related payment rate for the nine months following the settle up for a nursing facility which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary]. The property related payment rate for the rate year beginning July 1 following the nine month period is determined under part 9549.0060.

F. The settle up property related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1) must be updated in accordance with subpart 2, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with subparts 5, 6, and 7.

(3) The settle up building capital allowance shall be determined in accordance with subpart 8 or 9.

(4) The equipment allowance shall be updated in accordance with subpart 10 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle up property related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

G. The property related payment rate for the nine months following the settle up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property related payment rate for the rate year beginning July 1 following the nine month period in item G must be determined under this part.

I. A newly constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property related payment rate until the settle up property related payment rate is determined under this subpart.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle up shall be equal to the settle up real estate taxes and special assessments payment rate.

Statutory Authority: *MS s 256B.41; 256B.431; 256B.502*

History: *9 SR 2659; 11 SR 866; 11 SR 1989; 13 SR 130; L 1992 c 513 art 7 s 136*

9549.0061 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS.

The total real estate taxes and actual special assessments and payments permitted under part 9549.0036, item CC must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659*

9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.

Subpart 1. **Total payment rate.** The total payment rate is the sum of the operating cost payment rate, the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

Subp. 2. **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate established in parts 9549.0010 to 9549.0080 unless the total payment rate being adjusted was subject to the private payment rate limitation.

Subp. 3. **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in part 9549.0060,

subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the commissioner on the basis of medical necessity.

Subp. 4. **Adjustment of total payment rate.** If the commissioner finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the commissioner shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the commissioner the entire overpayment within 120 days of receiving the written notification from the commissioner. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under part 9549.0080, any payments owed by the nursing facility or by the commissioner must be made within 120 days of written notification to the nursing facility of the commissioner's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the commissioner's ruling on the appeal. The annual interest rate charged must be the rate charged by the commissioner of the Department of Revenue for late payment of taxes, which is in effect on the 121st day after the written notification.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*

9549.0080 APPEAL PROCEDURES.

Subpart 1. **Scope of appeals.** A decision by the commissioner may be appealed by the nursing facility or a county welfare or human services board where all of the following conditions are met:

A. The appeal, if successful, would result in a change in the nursing facility's total payment rate.

B. The appeal arises from application of the provisions of parts 9549.0010 to 9549.0080, or 12 MCAR SS 2.05001-2.05016 [Temporary], or parts 9510.0010 to 9510.0480.

C. The dispute over the decision is not resolved informally between the commissioner and the appealing party within 30 days of filing the written notice of intent to appeal under subpart 2, item A.

Subp. 2. **Filing of appeal.** To be effective, an appeal must meet the following criteria:

A. The nursing facility must notify the commissioner of its intent to appeal in writing within 30 days of receiving the payment rate determination or decision which is being appealed. The written appeal must be filed within 60 days of receiving the payment rate determination or decision being disputed.

B. The appeal must specify:

(1) each disputed item and the reason for the dispute;

(2) the computation and the amount that the appealing party believes to be correct;

(3) an estimate of the dollar amount involved in each disputed item;

(4) the authority in statute or rule upon which the appealing party is relying in each dispute; and

(5) the name and address of the person or firm with whom contacts may be made regarding the appeal.

Subp. 3. **Resolution of appeal.** The appeal must be heard according to the contested case provisions in Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings. Upon agreement of both parties, the dispute may be resolved informally

through settlement or through modified appeal procedures established by agreement between the commissioner and the chief administrative law judge.

Subp. 4. **Payment rate during appeal period.** Notwithstanding any appeal filed under parts 9549.0010 to 9549.0080, the total payment rate established by the commissioner shall be the rate paid to the nursing facility while the appeal is pending. A nursing facility appealing under this part is subject to the limitation in part 9549.0070, subpart 2 pending resolution of the appeal. The nursing facility must give private paying residents notice, as required by Minnesota Statutes, section 256B.47, subdivision 2, of the total payment rate established by the commissioner that will be charged pending appeal. The nursing facility may give private paying residents notice, as required by Minnesota Statutes, section 256B.47, subdivision 2, of the total payment rate that will be charged if the nursing facility prevails in the appeal. If notice is given and the nursing facility prevails in the appeal, the nursing facility may adjust the private payment rate retroactive to the first day of the period covered by the appeal or to the 31st day after giving the notice, whichever is later.

Subp. 5. **Payments after resolution of appeal.** Upon resolution of the appeal, any overpayments or underpayments must be made according to part 9549.0070.

Statutory Authority: *MS s 256B.41 to 256B.502*

History: *9 SR 2659; L 1992 c 513 art 7 s 136*