PAGES 821-860

State Register

STATE OF MINNESOTA

IN THIS ISSUE:

VOLUME 1, NUMBER 21

NOVEMBER 30, 1976

Subscribers Hotline

Phone inquiries regarding subscriptions should be directed to Marjorie Borchard at (612) 296-8239.

How to Cite

Cite all material in the *State Register* by Volume number and page number.
Example: Volume 2, *State Register*, page 94 (short form: 2 S.R. 94).

State Register

Individual copies of the *State Register* may be purchased at either the Office of the State Register or the Documents Section, for $2.25.

Change of address notices, subscription or single-copy orders and undelivered copies should be sent to:

THE OFFICE OF THE STATE REGISTER
95 Sherburne, Suite 203
St. Paul, Minnesota 55103
296-8239

The *State Register* is the official publication of the State of Minnesota. It contains all executive orders, rules and notices filed with the Office of the State Register as of noon of the second Thursday preceding the Monday of publication. The text of documents published in the *State Register* is to be accorded the following presumptions:

(1) The rule or order was duly adopted, issued or promulgated;

(2) The rule or order was duly filed with the Secretary of State and available for public inspection at the day and hour endorsed thereon; and

(3) The copy of the rule or order published in the *State Register* is a true copy of the original.

Judicial notice shall be taken of material published in the *State Register*.

The *State Register* is published weekly, on Monday, by the State of Minnesota, Department of Administration, Office of the State Register, Suite 203, 95 Sherburne Avenue, St. Paul, Minnesota 55103, pursuant to Minn. Stat. § 15.0411. In accordance with expressed legislative intent that the *State Register* be self-supporting, the subscription rate has been established at $110 per year, and $85 per year for second and additional subscriptions, postpaid to points in the United States. Second class postage paid at St. Paul, Minnesota.

Contents

Rules

Proposed Rules

Official Notices

List of MSAR Rules Affected*

List of rules within the Manual of State Agency Rules affected by documents published in the State Register during the current quarter beginning October 1, 1976:

*New rules, both proposed and adopted, and which have never been disseminated or published, are not included in the List of MSAR Rules Affected. Rules which are listed as "uncodified" have been disseminated, but have never been published in the MSAR.

Board of Architecture, Engineering, Land Surveying and Landscape Architecture

Requirements for Licensure of Architects, Engineers, Land Surveyors and Landscape Architects

Rules as Adopted

AE&LS 2 In training classifications. There shall be a classification of Engineer-in-Training, [and] a classification of Land Surveyor-in-Training, **and a classification of Landscape Architect-in-Training**. (For examination of Engineer-in-Training see AE&LS 10, [and] for Land Surveyor-in-Training see AE&LS 11, **and for examination of Landscape Architect-in-Training see AE&LS 9.1.**)

AE&LS 3 Application for registration.

A. Before making formal application for examination, the applicant is requested to submit to the Board, on a preliminary letter-form, information relative to place and date of birth, time and place of schools attended and studies completed, [whether he graduated or not,] **status relative to graduation from such schools or completion of studies,** degree or degrees received, whether [he has taken] the Engineer-in-Training, [or] Land Surveyor-in-Training, **or Landscape Architect-in-Training** examination, [and whether he has passed or failed such examination, together with] **has been successfully completed and** a chronological record of [his] **personal** employment, with all dates and with complete information relative to duties and type of work performed, and particularly outlining the applicant's responsibilities in charge of the whole or any part thereof. The preliminary letter-form will be furnished an applicant upon request to the Board office. This information will be evaluated **by the appropriate member or members of the Board** and if the applicant is found [definitely] ineligible for **admission to the** examination at that time, he **or she** will be so notified **and given the reasons therefor** and no expense [to him] will have been incurred **by the applicant**. If [he] **the applicant** is apparently eligible at that time for **admission to the** examination, [he] **such applicant** will be so notified and a form will be sent [him] on which to make [his] formal application for [registration] **licensure** subject to the Rules and Regulations of the Board.

B. Applications for [registration] **licensure** shall be under oath and made on forms prescribed and furnished by the Board and shall be filled with the [Secretary-Treasurer] **Executive Secretary** of the Board at least sixty days before the date set for the Professional examinations accompanied by the payment of the examination fee **as specified in AE&LS 4 E. and F.**

C. Applications for examination as Engineer-in-Training [or], Land Surveyor-in-Training, **or Landscape Architect-in-Training** shall be **made** under oath and [made] on forms prescribed and furnished by the board and shall be filed with the [Secretary-Treasurer] **Executive Secretary** of the Board accompanied by the examination fee **as specified in AE&LS 4 F.**

(d) Remains unchanged.

AE&LS 4 Fees.

A. Applications for examination for certification as an Engineer-in-Training, [Land Surveyor-in-Training] **Landscape Architect-in-Training,** or [registration] **licensure** (or renewal of [registration] **licensure**) as an architect, professional engineer, [or] land surveyor, **or landscape architect,** shall be accompanied by a fee in the amount provided for herein. **The fee for examination for certification as Land Surveyor-in-Training shall be paid in the amount provided for herein upon approval of the application by the Board.**

(b) Remains unchanged.

C. The fee for [registration] **licensure**, or renewal of [registration] **licensure**, as an architect, professional engineer, [or] land surveyor, **or landscape architect** shall be [fifteen] ($15) [Dollars] **per year. The initial license fee shall be prorated at six month intervals during each biennium. The fee for months 24 to 18 shall be $30, for months 18 to 12 shall be $22.50, for months 12 to 6 shall be $15 and for months 6 to 0 shall be $7.50.** The renewal fee **for Fiscal Year 1978** shall be paid on or before [December 31 of each year,] **June 30, 1977 and biennially on or before June 30 of each even numbered year thereafter,** as required by Minn. Stat. § 326.10, subd. 4. The Board may delete from the Roster the name of any [registrant] **licensee** who fails to timely pay **the required** [his] renewal fee or **if such** [whose] renewal fee, **when** [if] paid by mail, is not postmarked on or before [December 31.] **June 30 of the year specified herein.**

D. A renewal fee shall be deemed to be a "delayed renewal fee", within the meaning of Minn. Stat. § 326.10, subd. 5 if it is not postmarked on or before [December 31.] **June 30 of the year specified herein.** The delayed renewal fee shall be Three ($3) Dollars for each profession in addition to the renewal fee provided for herein.

E. The fee for examination for [registration] **licensure** as

an architect, professional engineer, [or] land surveyor, **or landscape architect** shall be One Hundred ($100) Dollars. An applicant for examination in more than one branch of engineering shall submit a separate examination fee for each such additional branch of engineering for which [he] **such applicant** has applied for examination.

F. The examination fee for certification as an Engineer-in-Training, [or] Land Surveyor-in-Training, **or Landscape Architect-in-Training** shall be Thirty ($30) Dollars. Such fee shall be applied in payment of the One Hundred ($100) Dollars examination fee for [registration] **licensure** as provided in paragraph E. hereof, provided that the applicant for [certification] **licensure** shall have completed all examinations required by the Board for [registration] **licensure** within ten (10) years from the date of certification as an Engineer-in-Training [or], Land Surveyor-in-Training**, or Landscape Architect-in-Training**. In the event that the applicant for [certification] **licensure** has not completed all examinations for [registration] **licensure** within the ten-year period provided for herein, the examination fee for [registration] **licensure** shall be One Hundred ($100) Dollars.

(g) Remains unchanged.

H. In addition to all other fees for examination or registration, as provided in these Rules or Minn. Stat. § 326.10, subd. 1, the following schedule of fees shall be applicable:

(1) and (2) Remain unchanged.

3. for reissuance of a revoked, lost, destroyed or mutilated certificate of [registration] **licensure** of certificate as an Engineer-in-Training [or], Land Surveyor-in-Training, **or Landscape Architect-in-Training,** One ($1) Dollar;

4. for evaluation of transcripts to determine an applicant's educational qualifications for examination for [registration] **licensure** or certification as an Engineer-in-Training, [or] Land Surveyor-in-Training, **or Landscape Architect-in-Training, the fee may be not more than** Ten ($10) Dollars; provided, however, that in the case of transcripts of foreign universities which shall require translation, the fee [shall] **may** be **not more than** Thirty ($30) Dollars;

(5) Remains unchanged.

(i) Remains unchanged.

AE&LS 5 Certificate of registration. Certification of an applicant's technical qualifications by the National Council of Architectural Registration Boards **(NCARB),** [or the Committee on National Engineering Certification conducted by] **National Certification Committee of** the National Council of Engineering Examiners **(NCEE), or the Council of Landscape Architectural Registration Boards (CLARB)** may be accepted by the [Minnesota] Board as establishing such qualifications, and the applicant, in such instances, will not be required to pass further examination.

AE&LS 7 Requirements. It is required that the applicant submit evidence to the Board indicating that he is qualified to practice in the profession or field of major practice thereof, in which he seeks registration. The burden of proof is upon the applicant and he, therefore, should make every effort to present qualifications fully and clearly. Qualifications shall be established by one or more of the following methods:

(a) Remains unchanged.

B. By [passing] **successfully completing** an oral examination.

(c) Remains unchanged.

D. By submitting a **Council** Certificate prepared by the National Council of Architectural Registration Boards. (For architect applicants only.)

E. By submitting [a Certificate of Qualification] **an NEC Council Record** prepared by the [Committee on National Engineering Certification of the] **National Certification Committee of the** National Council of Engineering Examiners. (For engineer applicants only.)

F. By submitting a Council Certificate prepared by the Council of Landscape Architectural Registration Boards. (For landscape architect applicants only.)

Former (f) shall be redesignated as G.

Former (g) shall be redesignated as H.

AE&LS 8 Procedure.

(a) Remains unchanged.

B. An architect, **engineer, land surveyor, or landscape architect,** [registered] **licensed** by exemption and desiring a change of status may apply therefor and [his] **the applicant's** qualifications for such change will be determined by [(1)] written examination. [, or (2) oral examination and

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

submitting satisfactory exhibits of his technical qualifications. (The oral examination shall apply only to those having ten (10) or more years of independent lawful practice as a principal in the profession of architecture.)]

Former (c) is repealed and superseded by the following:

C. An applicant must take all parts of the "in-training" examination at one time. The applicant must pass the "in-training" examination prior to taking the professional examination, if applicable (see AE&LS 10(d)). The applicant must take all parts of the professional examination at one time.

D. An applicant who does not receive a passing grade in [the] **an** examination may make application to retake [the] **that** examination. Such application shall be accompanied by a re-examination fee as required under AE&LS 4. **The Board may require** [A] **an** applicant failing [to pass] an examination [twice,] **two or more times** [must] **to** submit evidence of improved qualifications before an additional retake examination is permitted. Only an acceptable [excuse] **reason** for non-appearance **for a scheduled examination** will permit the applicant to [retake his] **be rescheduled for such** examination.

E. Oral examinations [will] **may** be given each year at such times as may be designated by the Board. Written examinations will be given twice [a] **each** year **for engineer and land survey applicants and once each year for architectural and landscape architectural applicants**. Persons who file applications for [registration] **licensure by examination** and are **determined to be** eligible for **admission to the** examination will be informed by letter of the date and place of the examinations.

(f) Remains unchanged.

Former AE&LS 9(a)-(c) are repealed and superseded by the following:

AE&LS 9 Examination of architect applicants.

A. Education and experience. An applicant for licensure as an architect shall be required to pass a written examination as provided herein and may be required to appear before the Board for an oral examination for the purpose of verifying personal experience qualifications. To qualify for admission to such written examination, applicants shall present satisfactory evidence that they have:

1.Graduated from an architectural curriculum accredited by the National Architectural Accrediting Board (NAAB) at the time of their graduation or within two years subsequent to that graduation.

***2. Completed at least three (3) years of satisfactory professional experience after graduation under the supervision of licensed architects.**

3. Applicants may also qualify for admission to the examination provided that they submit to the Board satisfactory evidence of education and subsequent experience substantially equivalent to the above requirements and as set forth in Table I. The basis for determination of educational qualifications and equivalents are set forth in Table II. The basis for determination of experience qualifications and equivalents are set forth in Table III.

TABLE I — EDUCATION AND EXPERIENCE

Description	Professional Education Max. (yrs.)	Professional Experience Min. (yrs.)	Total Education and Experience
1. **Graduate of Accredited Architectural School ...	5	*3	8
2. Graduate of Accredited Architectural Engineering School			
5-year Course	5	*4	9
4-year Course	4	*5	9
3. Graduate of Non-Accredited Architectural or Architectural Engineering School			
5-year Course	5	*5	10
4-year Course	4	*6	10
4. Non-School Trained Applicant	0	13	13

***Professional experience must be acquired after graduation except that continuous experience gained before graduation will be evaluated by the Board. An applicant with qualified experience will be granted full credit for such experience, not to exceed a total of one (1) year. The remaining experience shall be after graduation. No credit will be given to architectural students for experience gained during summer vacations.**

****Accredited by the National Architectural Accrediting Board.**

TABLE II — EDUCATIONAL CRITERIA

Education Category	1st 2 yrs	Succeeding Years	Maximum Credit Allowed
1. First professional degree in architecture, or credits, where the degree program has been accredited by NAAB not later than two years after termination of enrollment.	75%	100%	5 yrs

2. First professional degree in architecture, or credits, where the degree program has not been accredited by NAAB.	75%	100%	4½ yrs.
3. Bachelor of architectural engineering degree, or credits, accredited by Engineers' Council for Professional Development (ECPD).	50%	100%	4 yrs.
4. Bachelor of architectural engineering degree, or credits, not accredited by ECPD.	50%	75%	3½ yrs.
5. Degree, or credits, in civil, mechanical, or electrical engineering accredited by ECPD.	50%	100%	3 yrs.
6. Degree, or credits, in civil, mechanical, or electrical engineering not accredited by ECPD.	50%	75%	2½ yrs.
7. Degree, or credits, in courses (university, college, Jr. college, technical school, etc.) other than architecture.	50%	50%	2 yrs.

Substitution of education listed in Table II for requirements for admission to NCARB Qualifying Examination shall be subject to the following conditions:

a. 32 semester credit hours or 48 quarter hours is considered to be one year. Fractions equal to, or greater than, one-half year will be counted one-half year and smaller fractions will not be counted.

b. An applicant working full time and simultaneously earning formal education credits from a college and university through evening or part-time courses will be allowed credit, prorated between education and training.

c. When credits are submitted from more than one college or university, they will be evaluated on the same basis as by the school last attended.

d. Credits from a foreign college or university may be evaluated by a faculty representative, School of Architecture, University of Minnesota on the same basis as candidates for B.Arch degree from the University of Minnesota. Any cost of translation or evaluation must be borne by the applicant. Credits for foreign architectural degrees may be granted in categories 1 or 2 in Table II, as determined by the Board.

e. For non-graduates, each year of approved, architectural education successfully completed at the college level, is deemed equivalent to two (2) years of experience. (Minimum total — 13 years.)

TABLE III — EXPERIENCE CRITERIA

	Credit Allowed	Maximum Credit Allowed
1. Experience as an employee under the direct supervision of a licensed architect.	100%	no limit
2. Practical training of more than three continuous months, prior to acquisition of an architectural degree, in offices of licensed architects.	100%	1 year
3. Master or PhD degree in architecture, or credits, except where the degree is the first professional degree.	100%	1 year
4. Teaching or research in NAAB accredited architectural curriculum.	100%	1 year
5. Employment by government agencies, consulting engineers, general contractors, interior designers, landscape architects, or city planners, in areas directly related to construction, and those self-employed in one of the above. Such experience not under the direct supervision of a licensed architect.	50%	2 years
6. Employment by government agencies, including the military, when diversified and comparable to employment in the office of a licensed architect practicing as a principal, such work is directly related to architectural work, in a recognized training program and under the direct supervision of a licensed architect employed in the capacity of manager of the agency's architectural activities.	100%	no limit
7. Same as "6" above except experience is not structured.	50%	2 years
8. Employment by organizations that have employees performing architectural services in connection with projects used or owned by that organization, said employment is directly related to architectural work, is diversified and under the direct supervision of a licensed architect employed in the capacity of manager of the organization's architectural activities.	100%	no limit
9. Same as "8" above except where services are limited to prototype projects.	50%	2 years

Substitution of experience listed in Table III shall be subject to the following conditions:

a. No training prior to graduation from high school will be accepted.

b. A minimum of one year of training earned in offices of licensed architects practicing as principals may be required at the discretion of the Board.

c. One year of teaching is considered to be total teaching load of 20 semester credit hours or 30 quarter credit hours.

d. When training is earned by work with such agencies as VISTA, Peace Corps and advocacy planning, the applicant shall submit a statement with the application outlining briefly, but concisely, duties for which responsible and the names and professional status of supervisory personnel. For credits to be granted under this category, training must be in areas directly related to the practice of architecture.

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

B. Application. An applicant may request to be admitted to an examination if such applicant has completed, or is within six months of completing, educational and experience requirements contained herein. Any applicant lacking up to six months of qualifying architectural experience at the time of successful completion of the registration examination may not be licensed until such experience requirements have been met.

C. Written examination.

1. NCARB mark series professional examination. Administered once annually during the month of December in the format provided by the National Council of Architectural Registration Boards to those applicants approved by the Board for admission to the examination at a time and place as determined by the Board. Qualification requirements for admission to the Professional Examination includes a degree from an architectural curriculum accredited by the National Architectural Accrediting Board, at least three years of diversified, qualifying architectural experience and/or successful completion of the NCARB Qualifying Examination. Any person failing one or more parts of the Professional Examination must retake the entire examination.

2. NCARB qualifying examination. Administered once annually during the month of June in the format provided by the National Council of Architectural Registration Boards to those applicants approved by the Board for admission to the examination at a time and place as determined by the Board. Qualification requirements for admission to the Qualifying Examination include 12 years of combined architectural education and experience as provided in Tables I, II and III, herein. Any person failing one or more parts of the Qualifying Examination must retake the failed parts.

3. Handbooks, tables, reference books and handheld electronic calculators may be used when authorized by the Board.

Former AE&LS 11(a)-(d) are repealed and superseded by the following:

AE&LS 11 Examination of land surveyor applicants.

A. Education and experience. Each applicant for licensure as a land surveyor shall be required to appear before the Board for the purpose of an oral examination and to pass written examinations as provided hereinafter. Oral examinations may not be required of those comity applicants licensed under AE&LS 7 G. which rule applies to those licensed in one or more states other than Minnesota. In the case of comity applicants, the same minimum requirements will be demanded as existed in Minnesota at the time of the original licensure as land surveyor in such other state. To qualify for oral and written examination, applicants shall present satisfactory evidence that they have:

1. Graduated from a 4-year land surveying curriculum, approved by the Board.

2. Completed at least three (3) years of qualifying land surveying experience, after graduation, satisfactory to the Board.

3. Prospective applicants may qualify for licensure by examination provided they submit to the Board satisfactory evidence that their education and subsequent experience are substantially equivalent to the requirements set forth in the following table:

Classification	Education in Years	Experience in Years	Total Education & Experience*
**Graduate of 4-year land surveying curriculum approved by the Board	4	3	7
Graduate of other Bachelor of Science Curriculum approved by the Board	3	5	8
***Non-Graduate	0-3	6-9	9

*Requirements effective January 1, 1977.

**All applicants for licensure as land surveyor will be required to hold a degree from a Bachelor of Science curriculum approved by the Board or its educational equivalent effective January 1, 1985.

***A minimum of two years of qualifying education will be required as of January 1, 1981.

4. Recognized equivalent education. The education requirement of an applicant whose education was not obtained in a Bachelor of Science curriculum approved by the Board will be accepted only if such education is determined by the Board to be equivalent to such curriculum. The applicant will be required to submit a transcript of grades for evaluation by the Board to determine the credit to be allowed for such education. The applicant will be informed, in writing, of any course requirements lacking for equivalent education.

5. All applicants for licensure, by examination, as land surveyor in Minnesota must have completed one year of education leading to a B.S. degree including 8 quarter credits of surveying to take the Land Surveyor-in-Training examination and must have completed two years of education leading to a B.S. degree including 16 quarter credits of surveying or related courses to take the final examinations for Land Surveyor. This requirement is effective January 1, 1981.

B. Requirements for admission to examination. The Board may subject an applicant to such examinations as

may be deemed necessary to establish the qualifications of such applicant. Oral and written examinations shall be held at such times and places as the Board may direct.

1. Land surveyor-in-training. Any applicant who is a graduate of or is within three (3) months of graduating from, a 4-year land surveying curriculum approved by the Board or has equivalent education, may be admitted to the Fundamentals of Land Surveying Examination (LSIT). Non-graduates must have a minimum of two years of approved education and three years of qualifying experience.

2. Professional practice. The applicant must have successfully completed the Fundamentals of Land Surveying Examination (LSIT) and have had a total of seven or more years of combined land surveying education and qualifying land surveying experience as shown in the table herein. After the applicant has submitted a formal application for admission to the Professional Practice Examination, such applicant may be required to appear before the Board for an oral examination. The applicant may be called to appear for an oral examination where evidence of personal qualifications will be reviewed and the educational and experience record evaluated to determine eligibility for admission to the Professional Practice Examination.

C. Examinations.

1. Fundamentals of land surveying (LSIT). Consists of an eight-hour examination. Failure of either the morning or afternoon portion of the examination will require the applicant to retake the entire eight-hour examination. Successful completion of this examination qualifies the applicant for a Land Surveyor-in-Training Certificate.

2. Professional practice. Consists of two (2) four-hour examinations. Failure of one or both of the four-hour sections of this examination will necessitate retaking the failed section. Successful completion of the Professional Practice Examination qualifies the applicant for licensure as a Land Surveyor in Minnesota upon payment of the license fee.

3. Reference materials may be used when permitted by the Board.

D. A Syllabus for written examination in Land Surveying has been approved by the Board. It may be revised or updated periodically, as required. A copy of the current Syllabus may be obtained from the Board office by the prospective applicant prior to making application for examination.

Former AE&LS 12 is repealed and superseded by the following:

AE&LS 12 Rules of professional conduct. The Rules of Professional Conduct hereinafter set forth are adopted for the purpose of implementing the laws and regulations governing the practice of architecture, engineering, land surveying and landscape architecture including, but not limited to, Minn. Stat. § 326.11. These Rules shall be applicable to and binding upon each person, corporation or partnership subject to the regulatory jurisdiction of the Board (hereinafter referred to as licensee) and each person subject to the control of the licensee.

Each licensee who holds a certificate of licensure issued by the Board is charged with knowledge of the Rules of Professional Conduct hereinafter set forth or as such Rules may be amended from time to time. In the exercise of the privileges and rights granted by such certificate of licensure, the licensee shall conform his professional conduct to the public and to the Board in accordance with the provisions of these Rules, and shall, as a condition of his licensure, subscribe to and agree that he will conduct his practice in accordance with the provisions thereof.

A. Personal conduct.

1. A licensee shall avoid any act which may diminish public confidence in the profession and shall, at all times, conduct himself, in all of his relations with his clients and public, so as to maintain its reputation for professional integrity.

2. A licensee shall not submit a materially false statement or fail to disclose a material fact requested in connection with his application for certification or licensure in this state or any other state.

3. A licensee shall not further the application for certification or licensure of another person known by him to be unqualified in respect to character, education, or other relevant factor.

4. A licensee shall not:

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface**. Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

a. circumvent a Rule of Professional Conduct through actions of another;

b. engage in illegal conduct involving moral turpitude;

c. engage in conduct involving dishonesty, fraud, deceit or misrepresentation;

d. engage in conduct that adversely reflects on his fitness to practice his profession;

e. permit his name or seal to be affixed to plans, specifications or other documents which were not prepared by him or under his direct supervision.

B. Conflict of interest.

1. A licensee shall avoid accepting a commission where duty to the client, or the public, would conflict with the personal interest of the licensee or the interest of another client. Prior to accepting such employment, the licensee shall disclose to a prospective client such facts as may give rise to a conflict of interest.

2. A licensee shall not accept compensation for services relating or pertaining to the same project from more than one party unless there is a unity of interest between or among the parties to the project and unless the licensee makes full disclosure and obtains the express consent of all parties from whom compensation will be received.

3. A licensee shall not, directly or indirectly, solicit or accept any compensation, gratuity, or item of value from contractors, their agents or other persons dealing with the client or employer in connection with the work for which the licensee has been retained without the knowledge and approval of the client or the employer.

C. Improper solicitation of employment.

1. A licensee shall seek and engage in only such professional work or employment as such professional is competent and qualified to perform by reason of education, training or experience.

2. A licensee shall not accept employment to replace another professional except with his express knowledge, or unless the employment of such other professional by the client has been terminated.

3. A licensee shall not falsify or misrepresent the extent of his education, training, experience or qualifications to any person or to the public; nor shall he misrepresent the extent of his responsibility in connection with any prior employment.

4. A licensee may prepare a brochure for the purpose of informing the public or any prospective employer of his qualifications, training or experience; provided, that such brochure shall not contain any false or misleading information concerning the professional or his employer, employees, associates, or joint venturers.

5. A licensee shall not tender any gift, pay, or offer to pay, directly or indirectly, anything of substantial value, whether in the form of a commission or otherwise, as an inducement to secure employment; provided, that this Rule shall not prohibit the professional from paying a commission to a licensed employment agency for securing a salaried position.

6. A licensee who is a regular full-time employee and who accepts other part-time employment shall not, without the express consent of his regular employer, use his employer's:

a. equipment,

b. time, or

c. office, to seek or accept part-time work.

D. False or malicious statements. A licensee shall make no false or malicious statements which may have the effect, directly or indirectly, or by implication, of injuring the personal or professional reputation or business of another member of his profession.

E. Knowledge of improper conduct by others.

1. A licensee who has knowledge or reasonable grounds for believing that another member of his profession has violated any statute or rule regulating the practice of his profession shall have the duty of presenting such information to the Board.

2. A licensee, when questioned concerning any alleged violation on the part of another person by any member or authorized representative of the Board commissioner or delegated to conduct an official inquiry, shall neither fail nor refuse to divulge such information as he may have relative thereto.

F. Action by other jurisdiction. Convictions of a felony without restoration of civil rights, or the revocation or suspension of the certificate of licensure of a licensee by another jurisdiction, if for cause which in the State of Minnesota would constitute a violation of law or of these Rules, shall be deemed to be a violation of these Rules of Professional Conduct. Any licensee adjudged mentally incompetent by a court of competent jurisdiction shall, until he is restored to mental competency, be

deemed to be incompetent to practice his profession within the meaning of Minn. Stat. § 326.11, subd. 2.

G. Employment on the basis of merit. A licensee as an employer, shall refrain from engaging in any discriminatory practice prohibited by law and shall, in the conduct of his business, employ professional personnel solely upon the basis of merit.

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

PROPOSED RULES

Department of Health
Board of Health
System to Monitor Hospital Rates

Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on January 5, 1977, commencing at 9:00 a.m. and continuing until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Steve Mihalchick, Hearing Examiner, Office of Hearing Examiners, Room 300, 1745 University Avenue, St. Paul, Minnesota (Telephone: 296-8112) either before the hearing or within twenty (20) days after the close of the hearing.

These proposed rules, if adopted, will establish a system for the review of any rate change proposed by hospitals in this state. Copies of the proposed rules are now available and one free copy may be obtained by writing to Kent Peterson, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, 55440. Additional copies will be available at the door on the date of the hearing. The agency's authority to promulgate the proposed rules is contained in Laws of 1976, ch. 296, art. II. A "Statement of Need" explaining why the agency feels the proposed rules are necessary and a "Statement of Evidence" outlining the testimony they will be introducing will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection.

Please be advised that pursuant to Minn. Stat. § 10A.01, subd. 11 (1974) any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five (5) days of the commencement of such activity by the individual.

Warren R. Lawson, M.D.
Secretary and Executive Officer

Rules as Proposed

Chapter Twenty-Eight

MHD 471 Scope.

A. All acute care hospitals licensed pursuant to Minn. Stat. §§ 144.50 to 144.58 are subject to the requirements of the Minnesota Hospital Rate Review System established by these rules.

B. Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minn. Stat. §§ 144.50 to 144.58, are not subject to the requirements of the Minnesota Hospital Rate Review System. Where costs incurred through the operation of these beds are co-mingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal step-down requirements for allocation of costs as stated by 20 CFR 405.453 (Medicare).

C. Citations of Federal law or Federal regulations incorporated in these rules are for those laws and regulations then in effect on April 1, 1976.

MHD 472 Definitions. For the purposes of these rules, the following terms have the meanings given them:

A. "Accounting period" means the fiscal year of a hospital which is a period of twelve consecutive months established by the governing authority of a hospital for purposes of accounting.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care.

C. "Applicant" means a voluntary nonprofit rate review organization which has applied to the board for approval or renewed approval of its reporting and review procedures.

D. "Auxiliary enterprises" means significant continuing revenue-producing activities which, while not related directly to the care of patients, are businesslike activities commonly found in health care institutions for the convenience of employees, physicians, patients and/or visitors:

1. An activity is significant if either its revenues or direct costs exceed $.20 per inpatient day;

2. An activity is businesslike if it has related direct costs equal to at least 25% of its revenues;

3. Irrespective of the above criteria, all parking lots, private physicians' offices, and retail operations are considered to be auxiliary enterprises.

E. "Beds" means the average number of beds in a hospital which are in place and operating with staff

regularly assigned to them during an accounting period. This number need not be equivalent to the licensed or constructed bed capacity but it shall be equivalent to the average number of those beds commonly considered to be set up and staffed during an accounting period.

F. "Burden of proof" means the burden of persuasion by the preponderance of the evidence.

G. "Charges" means the regular amounts charged to both paying patients and insurers who receive services, irrespective of any discounts, deductions, or other reductions in these charges which, by contract or other agreement, may be applicable.

H. "Cost" means the amount, measured in money, of cash expended or other property transferred, services performed or liability incurred, in consideration of goods or services received or to be received.

I. "Emergency services" are those inpatient hospital services and outpatient hospital diagnostic services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

J. "Emergency visit" means an admission of a patient to a hospital which maintains a distinct emergency service center for purposes of receiving emergency services.

K. "Expanded facility" means any expansion or alteration in the scope of service of an institution subject to the provisions of the Minnesota Certificate of Need Law, Minn. Stat. §§ 145.71 to 145.84, or § 1122 of the Social Security Amendments of 1972, Public Law 92-603, according to the definitions contained in these laws and the current regulations sanctioned by them.

L. "Expense(s)" means costs that have been incurred in carrying on some activity and from which no benefit will extend beyond the period for which the expense is recorded.

M. "Fiscal year" means that period of twelve consecutive months established by the State for the conduct of its business.

N. "Inpatient hospital services" means the following items and services furnished by a hospital to an inpatient of such a hospital:

1. Bed and board;

2. Nursing services and other related services;

3. Use of hospital facilities;

4. Medical social services;

5. Drugs, biologicals, supplies, appliances and equipment;

6. Certain other diagnostic or therapeutic items or services; and

7. Medical or surgical services provided by certain residents-in-training.

O. "Loss" means the excess of all expenses over revenues for an accounting period or the excess of all or the appropriate portion of the cost or assets over related proceeds, if any, when items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off.

P. "Non-revenue center" means a service center which incurs direct operating expenses but which does not generate revenue directly from charges to patients for services. These centers, which rely on revenue from revenue centers to meet their expenses, may include such service centers of a hospital as:

1. General services, including:

a. Dietary services;

b. Plant operation and maintenance services;

c. Housekeeping services;

d. Laundry services; and

e. Other services.

2. Fiscal services;

3. Administrative services; and

4. Medical care evaluation services.

Q. "Outpatient services" mean those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and which are not inpatient services.

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

R. "Outpatient visit" means an admission of a patient to a hospital which maintains a distinct outpatient diagnostic service center for purposes of providing outpatient services.

S. "Program" means the reporting and review procedures proposed by an applicant.

T. "Quarter" means that period of the fiscal year corresponding to a three-month period of time for which the State regularly gathers information for the conduct of its business. For purposes of these rules, a fiscal year is composed of four quarters corresponding to the following groupings of months: a quarter is defined by the time period represented by the months of July, August and September; a quarter is defined by the time period represented by the months of October, November and December; a quarter is defined by the time period represented by the months of January, February and March; and, a quarter is defined by the time period represented by the months of April, May and June.

U. "Rate" means the average revenue for each inpatient admission

$$\frac{\text{Total Revenue}}{\text{Number of Inpatient Admissions}}$$

for a full accounting period. "Adjusted rate" means the average revenue for each adjustment admission

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by:

$$\text{Number of Outpatient Visits} \times \frac{\text{Total Outpatient Revenue}}{\text{Number of Outpatient Visits}}$$

$$\frac{1}{\text{Inpatient Revenue Per Admission}} \text{ PLUS } \text{The Number of Inpatient Admissions}$$

The rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report.

V. "Restricted funds" means funds donated to the hospital which are restricted for a specific purpose by the donor.

W. "Revenue(s)" or "income(s)" means the value at the hospital's full established charges of all hospital services rendered to patients, regardless of the amounts actually paid to the hospital by or on behalf of patients.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

1. Daily patient services (routine services) including:

a. Medical services;

b. Surgical services;

c. Pediatric services;

d. Intensive care services;

e. Psychiatric services;

f. Obstetric-gynecological services;

g. Newborn nursery services;

h. Premature nursery services;

i. Other routine services.

2. Other nursing services (special services), including:

a. Operating room services;

b. Recovery room services;

c. Delivery and labor room services;

d. Central services and supply services;

e. Intravenous therapy services;

f. Emergency services;

g. Other special services.

3. Other professional services (ancillary services), including:

a. Laboratories;

b. Blood bank;

c. Electrocardiology;

d. Radiology;

e. Pharmacy;

f. Anesthesia;

g. Physical therapy;

h. Other special services.

Y. "Service center" means an organizational unit of a hospital for which historical and projected statistical and financial information relating to revenues and expenses are accounted. A service center may be a routine, special, or ancillary service center. A service center may also be a revenue center or a non-revenue center.

Z. "System" means the Minnesota Hospital Rate Review System and any applicant approved to operate it or the board.

A_1. "Third party payors" mean insurers, health maintenance organizations licensed pursuant to Minn. Stat. ch. 62D, and governmental insurance programs, including the health insurance programs authorized by Title V, Title XVIII and Title XIX of the United States Social Security Act (Medicare and Medicaid).

B_1. "Unrestricted funds" mean funds not restricted by the donor and funds designated by the governing authority of the hospital, not including revenues in excess of expenses.

MHD 473 The Minnesota hospital rate review system. The Minnesota Hospital Rate Review System is established. This system shall be operated by the board or any voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the board, pursuant to MHD 496. The system shall consist of reports, administrative procedures, and standards.

MHD 474 Report requirements. The system shall require annual financial information and rate revenue and expense, and interim increase reports.

A. Annual financial information report. Each hospital shall submit an annual financial information report to the system. This report shall include:

1. a. A balance sheet detailing the assets, liabilities, and net worth of the hospital. This balance sheet should include information on:

(1) Current assets, including:

(a) Cash;

(b) Marketable securities;

(c) Accounts and notes receivable;

(d) Allowances for uncollectable receivables and third party contractuals;

(e) Receivables from third party payors;

(f) Pledges and other receivables;

(g) Due from other funds;

(h) Inventory; and

(i) Prepaid expenses.

(2) Plant capital allowances, including historical cost of, price level increments related to and accumulated depreciation related to:

(a) Land;

(b) Land improvements;

(c) Buildings;

(d) Leasehold improvements;

(e) Building equipment;

(f) Movable equipment; and

(g) Construction in progress.

(3) Deferred charges and other assets, including:

(a) Other assets;

(b) Investments in non-operating property, plant and equipment;

(c) Accumulated depreciation on investments in non-operating plant and equipment; and

(d) Other intangible assets (e.g., good will, unamortized borrowing costs).

(4) Current liabilities, including:

(a) Notes and loans payable;

(b) Accounts payable;

(c) Accrued compensation and related liabilities;

(d) Other accrued expenses;

(e) Advances from third party payors;

(f) Payable to third party payors;

(g) Due to other funds;

(h) Income taxes payable; and

(i) Other current liabilities.

(5) Deferred credits and other liabilities, including:

(a) Deferred income taxes;

(b) Deferred third party revenue;

(c) Long-term debt; and

(d) Fund balances.

(6) In the case of hospitals owned by, operated by, affiliated with, or associated with an organization, corporation, or other hospital(s), a statement of the flow of funds between the hospital and that organization, corporation or other hospital(s). This statement shall detail all transactions between the hospital and the organization, corporation or other hospital(s).

b. In the event that a hospital maintains a balance sheet which includes information which differs from the information required by the balance sheet recommended by MHD 474 A.1.a., above, the hospital may substitute its balance sheet. This balance sheet shall include a narrative description of the scope and type of differences between its balance sheet and that balance sheet recommended by MHD 474 A.1.a., above.

2. a. A detailed statement of income and expenses, including:

(1) Gross revenue from and expenses directly attributable to revenue centers;

(2) All operating revenues and expenses other than those directly associated with patient care;

(3) Reductions in gross revenues that result from charity care, courtesy discounts, contractual adjustments, administrative and policy adjustments, provision for bad debts, and other factors;

(4) Direct expenses incurred by the research and educational, general, fiscal, and administrative service centers;

(5) Direct revenue and expense received or incurred from non-hospital operations; and

(6) A statement of expenses by a natural classification of expenses for the hospital as a whole. The natural classification of expenses may include such factors as:

(a) Salaries and wages, including:

(i) Management and supervision;

(ii) Technicians and specialists;

(iii) Registered nurses;

(iv) Licensed practical nurses;

(v) Aides and orderlies;

(vi) Clerical and other administrative employees;

(vii) Environment and food service employees;

(viii) Physicians;

(ix) Non-physician medical practitioners;

(x) Vacation, holiday, sick pay, and other non-worked compensation.

(b) Employee benefits, including:

(i) F.I.C.A.;

(ii) State unemployment insurance and federal unemployment insurance;

(iii) Group health insurance;

(iv) Pension and retirement;

(v) Workmen's compensation insurance; and

(vi) Group life insurance.

(c) Professional fees — medical, including:

(i) Physicians' remuneration; and

(ii) Therapists and other non-physician.

(d) Other professional fees, including:

(i) Consulting and management services;

(ii) Legal services; and

(iii) Auditing services.

(e) Special departmental supplies and materials.

(f) General supplies, including:

(i) Office and administrative supplies;

(ii) Employee wearing apparel;

(iii) Instruments and minor medical equipment which are non-depreciable;

(iv) Minor equipment which is non-depreciable; and

(v) Other supplies and materials.

(g) Purchased services, including:

(i) Medical — purchased services;

(ii) Repairs and maintenance — purchased services;

(iii) Medical school contracts — purchased services;

(iv) Management services;

(v) Collection services; and

(vi) Other purchase services.

(h) Other direct expenses, including:

(i) Depreciation, amortization, and rental or lease expenses necessary to maintain an adequate plant capital fund, pursuant to MHD 487 A.1.b.;

(ii) Utilities — electricity;

(iii) Utilities — gas;

(iv) Utilities — water;

(v) Utilities — oil;

(vi) Other utilities;

(vii) Insurance — professional liability;

(viii) Insurance — other;

(ix) Licenses and taxes other than income taxes;

(x) Telephone and telegraph;

(xi) Dues and subscriptions;

(xii) Outside training sessions;

(xiii) Travel; and

(xiv) Other direct expenses.

b. In the event that a hospital maintains accounts which include information resulting in detailed statements of income and expense which differ from the information required by the statement of income and expense recommended by MHD 474 A.2.a., the hospital may substitute its statement of income and expenses. This statement shall include a narrative description of the scope and type of differences between its statement of income and expenses and that statement recommended by MHD 474 A.2.a.

3. An unaudited copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406 (b). This cost report shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

4. Attestation by the governing authority of the hospital or its designee that the contents of the report are true.

5. Attestation by a qualified, independent public accountant that the contents of the balance sheet and statement of income and expense are true and conform to the bases for judging the reasonable use of finances in a hospital, as established by MHD 487 A.

B. Rate revenue and expense report.

1. Each hospital shall submit a report of rate revenue and expense to the system on an annual basis. This report shall include statistical and financial information for:

a. The hospital's last full and audited accounting period prior to the accounting period during which a hospital files this report with the system. This period shall be known as the prior year. Information for the prior year shall be actual.

b. The hospital's full accounting period during which a hospital files this report with the system. This period shall be known as the current year. Information for the current year shall be actual and estimated according to the following:

(1) Information for at least the first eight months shall be actual;

(2) Information for the last four months may be estimated.

c. The hospital's next subsequent full accounting period following the accounting period during which the report is filed with the system. This period shall be known as the budget year. Information for the budget year shall be projected.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital.

b. The number of admissions for the hospital and for each appropriate service center.

c. The average number of full-time-equivalent employees during each accounting period for the hospital and for each of its service centers. An employee or any combination of employees which are reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

d. The number of beds available for the hospital and for each appropriate routine service center.

e. The average annual occupancy rate for the hospital and for each appropriate routine service center.

f. The number of outpatient clinic admissions (visits) for the hospital.

g. The number of emergency admissions (visits) for the hospital.

h. The number of units of service provided by each of the hospital's other service centers. The hospital shall select the statistic that best measures the level of activity for a particular function or service center and that, in addition, is compiled on a routine basis by the hospital to serve as the appropriate unit of service for each of its service centers.*

3. Financial information for the rate revenue and expense report shall include:

a. An interim financial statement of the hospital which shall include an interim balance sheet and an interim income and expense statement for the current year only. The balance sheet and income and expense statement shall conform to the requirements of MHD 474 A.1. and MHD 474 A.2. This financial statement shall contain a minimum of six months of actual information for the current year.

b. A statement of expenses for the hospital and for each of its service centers and a statement according to natural classifications of expenses as provided by MHD 474 A.2.a.(6).

c. A statement detailing the accounting method used to allocate expenses from among the non-revenue centers to revenue centers, which shall detail compliance with the offsets to costs and allocation of costs specified by the bases for judging stated by MHD 487 A.

d. A statement of total direct and indirect costs for the hospital and for each of its service centers after the step-down allocation of expenses.

e. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of patient days outstanding at the end of each period.

f. A statement of changes in financial position showing the source and application of all funds for each period.

4. The report of rate revenue and expense shall also contain the following information:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution.

b. Attestation by the hospital's governing au-

*For example, although patient days might be used as the unit of service for daily patient services, treatments, procedures, visits, hours or other statistics would be the applicable measure of activity in other service centers.

thority or its designee that the rates are set equitably and without discrimination among insurers.

c. In the case of a hospital with expanded facilities, a copy of the hospital's report used to obtain a certificate of need for the expanded facility which projects the patient and service activity levels of the expanded facility for its first five years of operation.

C. Interim increase reports.

1. Each hospital desiring to amend or modify rates for the budget year stated in the rate revenue and expense report then on file with the system to an extent exceeding the allowable increase limit prescribed according to MHD 504, shall submit an interim increase report.

2. In instances where changes in rates during the budget year are the result of legislative policy and appropriations to hospitals subject to these rules which are operated by the commissioner of public welfare, this report is not required.

3. The interim increase report shall include statistical and financial information for:

a. The period of the budget year immediately preceding the effective date of amendments or modifications to the rates for the budget year which are stated in the rate revenue and expense report then on file with the system. Data for this period shall be actual for all expired months of the budget year, excepting the sixty-day period immediately preceding the filing of this report for which data may be projected.

b. The period immediately subsequent to and including the effective date of these amendments or modifications which terminates at the end of the last day of the budget year. Information for this period shall be projected on the basis of these rate amendments or modifications.

4. Statistical information for each period established by MHD 474 C.3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.2., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by MHD 474 C.3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.3., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

6. This report shall also include a narrative statement describing the reason for amendments or modifications to the hospital's rates.

MHD 474-480 Reserved for future use.

MHD 481 Administrative procedures.

A. General provisions for filing of reports.

1. Forms to be specified. The system shall design and issue forms as necessary for meeting the requirements of reports established by these rules. These forms shall contain clear instructions for their completion.

2. All documents may be filed personally or by the United States Postal Service with the system at the system's official offices during normal business hours.

3. The system shall establish a method of filing which shall insure that reports and other documents are ordered, filed, designated and dated in such a manner that facilitates easy public access to the contents of those reports, documents, and other information as required by these rules. These files shall be open to the public inspection during normal business hours.

4. No report required by these rules shall be deemed to be filed until the system has ascertained the completeness of the report in accordance with the provisions of MHD 487 C.1.

B. Filing of report of annual financial information.

1. Each year, each hospital shall file a report of annual financial information as required by MHD 474 A. with the system within 120 days after the close of that hospital's full accounting period. The cost report of the hospital filed pursuant to the requirements of Title XVIII of the United States Social Security Act (20 CFR 405.406(b)) may be filed separately from the other requirements for the report of annual financial information, provided:

a. It is filed no later than the time it is required to

be filed with the Medicare Fiscal Intermediary as identified according to 20 CFR 405.651, et. seq. (Medicare). The hospital shall inform the system of this date when filing other information required by this report.

b. The report of annual financial information is considered incomplete until the receipt of the unaudited cost report, but the hospital is not considered in violation of rules until the date required by the Medicare Fiscal Intermediary for the submission of the unaudited Medicare cost report.

c. The audited Medicare cost report is submitted as soon as is practicable to substitute for the unaudited Medicare cost report. The submission of an audited Medicare cost report shall not affect the official filing date of a report of annual financial information.

2. Failure to file. Any hospital which fails to file the annual financial information report, and which has not requested an extension of time pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board and the appropriate health systems agency to this effect. Pursuant to Minn. Stat. § 144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate.

C. Filing of report of rate revenue and expense.

1. Each year, each hospital shall file a report of rate revenue and expense sixty days prior to the commencement of any accounting period of the hospital.

2. a. Failure to file. Any hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board and the appropriate health systems agency to this effect. Pursuant to Minn. Stat. § 144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate.

b. A hospital which fails to file a report of rate revenue and expense, and which has requested an extension of time, pursuant to MHD 481 G., to file that report may be charged an additional late fee as authorized by MHD 509 C.

c. A hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to MHD 481 G., to file that report shall not amend or modify its rates until sixty days after that hospital files that report with the system.

D. Filing of interim increase reports.

1. A hospital shall file an interim increase report sixty days prior to the effective date of any amendments or modifications to rates then on file with the system for the budget year if:

a. The proposed rate change exceeds the allowable increase limit established according to MHD 504.

b. Amendments or modifications to rates which are to become effective after the first day of the budget year and prior to the end of the last day of the budget year were not included in the report of rate revenue and expense then on file with the system.

c. It is not filed within ninety (90) days of any other interim increase or rate revenue and expense report filed by that hospital.

d. There are no reports, fees, or other documents or information due to the system from that hospital.

e. These provisions may be waived by the system if the hospital can show cause why they should be waived.

2. Failure to file.

a. A hospital which fails to file an interim increase report with the system when it is required to file such a report pursuant to MHD 474 C., shall be considered in violation of these rules.

b. If this violation is discovered by the system during the budget year, the system may require a hospital so violating these rules to adjust its rates to be consistent with the allowable increase limits until sixty days after the hospital properly files an interim increase report.

c. If this violation is discovered by the system subsequent to the expiration of the budget year during which the violation occurred, the system may investigate this violation, pursuant to MHD 487 B., in order to determine the effect of this violation upon the rates of the hospital. The system may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in rates, irrespective of the allowable increase limits, for the next two subsequent full accounting periods following the discovery of the violation.

d. In making any retrospective assessment of a hospital's compliance with requirements to file interim increase reports, the system shall recognize that actual rates for the budget year may exceed projected rates for that budget year by a reasonable amount due to slight

variations from projected information contained in the rate revenue and expense report then on file with the system. A reasonable amount may vary with the financial and statistical composition of each hospital but, it should never exceed one and one-tenth times the allowable increase limit for the accounting period in question.

3. Allowable increase limits: hospital calculation. In order for a hospital to determine the extent to which it may increase its rates during the budget year before it is required to submit an interim increase report, the hospital shall:

a. Add the four quarterly allowable increase limits established by the board, pursuant to MHD 504, which are appropriate for the budget year of the rate revenue and expense report then on file with the system. This calculation provides the hospital with an allowable increase limit for the budget year stated in percentage terms; then,

b. Subtract from the allowable increase limit for the budget year the percentage of rate increase for the hospital, if any, from the current year to the budget year, as stated in the rate revenue and expense report then on file with the system. To the extent that the remainder from this calculation is positive, the hospital may increase its rates for the hospital by this amount at any time during the budget year. Cumulative increases in the rates of the hospital over the budget year up to this amount do not require the submission of an interim increase report. The system should be advised by the hospital at the time that rates are being so increased, stating the reason for and general scope of such an increase. The next subsequent rate revenue and expense report of the hospital should detail these increases.

c. Amendments or modifications which do not exceed the allowable increase limit or provide for rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. These amendments or modifications shall be noted in the hospital's next subsequent rate revenue and expense report.

E. Application for variance in rate determination. If a hospital desires to adopt an alternative method of accounting, cost control, rate determination or payment which may affect the way in which the system proceeds in its assessment of that hospital's rates, it shall notify the system sixty days in advance of the effective date of this new method. Such notification shall detail the new method, including expected impacts upon hospital revenues, expenses and rates as well as the impact of the new method on the equity with which rates are set.

F. Filing of reports: multi-hospital corporations and other organizations operating more than one hospital. The system requires the filing of all reports for each individually licensed acute care hospital, as provided by MHD 474. A multi-hospital corporation or organization operating more than one hospital may act as the reporting organization for the hospital to the system. This reporting organization shall provide all information separately for each hospital it operates. The reporting organization shall also provide with this information, a statement detailing the financial relationship between each hospital it operates and the reporting organization, as required by MHD 474 A.1.a.(6), for the annual financial information report.

G. Filing of reports: extensions. Upon reasonable cause being shown by a hospital, the system may extend any period of time established for the submittal of any report or other information, or any period of time established for the performance of any other act permitted or prescribed by these rules, for an additional and specified period of time.

MHD 482-486 Reserved for future use.

MHD 487 Investigations, analysis and review standards. The system shall investigate, analyze and review all reports and other information it receives relating to hospital rates according to the following standards:

A. Bases for judging the reasonable use of finances in a hospital. In all investigations, analyses, and reviews conducted pursuant to Laws of 1976, ch. 296, art. II, §§ 1 through 9, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial requirements of hospitals. The rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

a. Current operating needs related to patient care. In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

(1) Direct patient care.

(a) Rates should provide finances to meet expenses in this category which may include salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification and any applicable taxes.

(b) The monetary value of services provided by members of religious orders, other organized religious or social service groups or organizations or by a unit of government, such as a county, may be included in rates, provided:

(i) That value does not exceed the amount that would have been paid to regular salaried hospital employees for the provision of the same services;

(ii) The maximum value for non-governmental services is the cash payment to the order, group or organization from the hospital;

(iii) That value is reduced by the expense incurred by the hospital for the provision of any room and/or board without charge to members of those orders, groups, or organizations.

(2) Interest expense.

(a) Rates should provide the finances necessary to recover costs incurred by the hospital due to necessary and proper interest on funds borrowed for operating and plant capital needs.

(b) Interest on funds borrowed for operating needs is the cost incurred for funds borrowed for a relatively short term. This interest is usually attributable to funds borrowed for such purposes as working capital for normal operating expenses.

(c) Interest on funds borrowed for plant capital needs is the cost incurred for funds borrowed for plant capital purposes, such as the acquisition of facilities and equipment, and capital improvements. These borrowed funds are usually long-term loans.

(d) Interest is necessary if it is:

(i) Incurred on a loan made to satisfy a financial need of the hospital. Loans which result in excess funds or investments should not be considered necessary;

(ii) Incurred on a loan made for a purpose reasonably related to patient care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost and which has been determined to have excess capacity, pursuant to MHD 487 A.4., or whose services have been determined to be inappropriate, pursuant to Public Law 93-641, § 1523 (a) (6) (National Health Planning and Resources Development Act of 1974), are not considered to be for a purpose reasonably related to patient care.

(e) Interest is proper if it is incurred at a rate not in excess of what a prudent borrower would have to pay in the money market existing at the time the loan was made.

(3) Educational program expenses.

(a) Rates should provide the finances necessary to recover the net cost to the hospital of providing educational activities which:

(i) Are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; and

(ii) Can be demonstrated to contribute to the preventive health education of the population of areas of patient origin which the hospital serves.

(b) "Approved educational activities" means formally organized or planned programs of study usually engaged in by hospitals in order to enhance the quality of patient care in a hospital. These activities shall be licensed where required by State law. Where licensing is not required, the hospital shall be able to demonstrate that it has received approval for its activity from a recognized national professional organization for the particular activity. Approved educational activities include those programs defined as approved by 20 CFR 405.116(f) (Medicare) and 20 CFR 405.421(e) (Medicare).

(c) "Net cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursement from grants, tuition and specific donations.

(d) "Orientation" and "on-the-job training" costs are recognized as normal operating costs of hospitals for employees of the hospital.

(e) The extent of costs incurred for the provision of educational activities contributing to the preventive health education of the population of the hospi-

tal's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency, pursuant to Public Law 93-641, § 1523 (a)(6). In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.

(4) Research program expenses. Rates should provide finances necessary to meet costs incurred by a hospital due to research programs which directly relate to daily patient care to the extent that non-patient revenue of the hospital is unavailable to offset these research costs. Rates should not provide finances necessary to meet costs incurred by a hospital due to research purposes, over and above usual patient care.

(5) Bad debt, charity allowances, courtesy discount allowances, and contractual allowance expenses.

(a) Rates should provide finances necessary to recover losses in revenue due to bad debts, charity allowances, courtesy discount allowances, and contractual allowances.

(i) "Bad debts" mean amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectible in money in the near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, courtesy discount allowances and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

(ii) "Charity allowances" mean the provision of care at no charge to patients determined to be qualified for care according to 42 CFR 53.111(f) and (g), in hospitals required to provide free care, pursuant to 49 U.S.C. § 291, et. seq. (The Hill-Burton Act).

(iii) "Contractual allowances" and "courtesy discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.

(aa) "Governmental contract adjustments" are those discounts from the established charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V, Title XVIII and Title XIX of the United States Social Security Act.

(bb) "Cost justified discounts" or "Differentials" mean those cash, trade, or quantity discounts or differentials from the established charges granted to certain patients, groups of patients, or third party payors at the time services are paid for. In order to include the amount of these discounts or differentials in rates, hospitals shall demonstrate that the value, as measured in money, of services or other benefits for an accounting period provided by certain patients, groups of patients, or third party payors to the hospital is equal to or greater than the aggregated amount, as measured in money, of the differential or discount granted to certain patients, groups of patients or third party payors for that same accounting period.

(cc) Discounts or differentials which are not cost justified in a manner consistent with MHD 487 A.1.a.(5) (a) (iii) (bb), above, shall not be included in rates but shall be treated as reductions in revenue and recorded by the hospital as such.

(b) These losses in revenues due to bad debts, charity allowances, courtesy discount allowances, and contractual allowances should be offset by available and applicable income from sources other than patients, as identified by MHD 487 A.2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

b. Plant capital needs. Rates should provide the finances necessary for various plant capital needs. Plant capital needs must be funded to be included in the rates. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to building and building equipment and movable equipment shall be placed in an identifiable fund. The annual increment to this fund should be:

(a) The greater of:

(i) The annual debt principal repayment on buildings, building equipment and movable equip-

ment. This principal repayment should be computed as though it were a level payment over the life of the debt instrument; or

(ii) The annual straight-line depreciation expense on buildings, building equipment and movable equipment.

(b) Plus inflation factors, annually determined and consistent with the established useful lives of buildings, building equipment, and movable equipment. These inflation factors shall be determined by the system on the basis of a price level adjustment index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of hospital buildings, hospital building equipment and movable equipment. The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, building equipment, and movable equipment.

(2) 100 percent of the inflation factors should be included by the hospital as the annual inflation factor unless the hospital has been determined to have excess capacity, as provided by MHD 487 A.4., or by the appropriate health systems agency and State Health Planning and Development Agency. In instances where excess capacity exists, the annual inflation factor and the level of debt principal payment in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1) should be reduced by the proportion of facilities determined to be in excess.

(3) The fund may not be sufficient to retire existing debt.

(4) The annual interest income earned from an investment of this fund annually should be used to reduce the inflation factor requirements for plant capital needs which are included in rates.

(5) In the event that sufficient financial resources are not available in this fund to meet plant capital needs (including the need for the replacement of existing facilities and the need for expansion of the scope of services to accommodate advances in medical technology, where either or both of these needs have received certificate of need approval when required), the additional financial resources should be acquired from:

(a) Income from appropriate sources other than patients;

(b) Borrowed funds or leases when income from sources other than patients can be demonstrated to be inadequate; or

(c) Approved inclusion in rates, when the hospital can demonstrate that insufficient resources exist in (i) or (ii) above, or when a hospital can demonstrate that inclusion in rates will result in a lower cost to patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of either or both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

(6) If a hospital can demonstrate that an emergency exists, then the hospital may, with certificate of need approval, include the cost of the emergency plant capital needs directly in its rates in a manner consistent with the previous financial practices of that hospital.

(7) If a hospital can demonstrate that the inclusion in the fund of any specific capital debt will result in a greater cost to patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the funding of plant capital needs as stated by these rules, then a hospital may choose not to fund the specific capital debt. In this instance, the hospital should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by MHD 487 A.1.b., above.

c. Incremental operating cash needs. Rates should provide finances to maintain a reasonable working capital allowance.

(1) The working capital allowance which may be included in rates is determined by the annual incremental difference between (net accounts receivable and inventories and prepaid expenses) and (salaries payable and other net payables) at the end of an accounting period. Any increase in working capital over the prior year, as stated in the first report of annual financial in-

formation submitted to the system by a hospital shall form the initial basis for the system's assessment of the reasonableness of the working capital allowance.

(2) The amount of working capital is dependent upon the number of days charges in accounts receivable for the hospital. These days charges should be stated in aggregate for an accounting period and a statement of accounts receivable by payor.

(a) Payors may include:

(i) Third party payors, including:

(aa) Medicare;

(bb) Medicaid;

(cc) Blue Cross;

(dd) Health maintenance organizations;

(ee) Other insurers; and

(ii) Paying patients.

(b) The number of days charges in accounts receivable for the hospital is determined by:

$$\frac{\text{Total Net Accounts Receivable At The End Of An Accounting Period}}{\text{Total Patient Charges For The Same Accounting Period}}$$

Actual Number Of Calendar Days In That Same Accounting Period

(3) "Net accounts receivable" means the dollar amount accounts receivable at the end of an accounting period less estimated discounts and differentials and reserve for uncollectibles.

(a) To the extent that the number of days charges in accounts receivable for a hospital increases from one accounting period to another subsequent accounting period, the hospital may increase rates to maintain its working capital allowance.

(b) To the extent that the number of days charges in accounts receivable for a hospital which is attributable to a particular payor or category of payors decreases, the working capital allowance should be reduced by that amount.

(4) "Inventories" means the dollar amount in inventories at the end of an accounting period. The dollar amount in inventories should not increase from one accounting period to another subsequent accounting period unless the hospital can justify such an increase as due to inflation, alterations in scope or volume of services offered.

(5) "Other net payables" means total payables at the end of an accounting period less all liabilities owed to third party payors and less the current portion of plant capital expenditure from the plant capital fund.

(6) The reasonableness of the working capital allowance depends upon factors including:

(a) The number of days charges in accounts receivable for a hospital compared with the number of days charges in accounts receivable for other hospitals determined by the system to share common characteristics. This number may be compared for hospitals in total;

(b) The amount of bad debts accrued by a hospital during an accounting period; and

(c) The amount of finances a hospital may hold in reserve funds.

2. Income from sources other than patients. In all investigations, analyses, and reviews conducted pursuant to these rules, the system shall recognize that hospitals have sources of income other than patients which are intended to be or may be used for the reduction of its rates. In meeting the reporting requirements of these rules, hospitals shall disclose the extent to which this income is used to offset costs and to provide service in such a manner as to reduce rates charged patients. This income includes:

a. Restricted endowment funds, specific purpose funds, and gifts.

(1) Income from endowment funds or gifts restricted by donors to provide for services for designated patients should be used to reduce the payment for those services.

(2) Income from endowment funds or gifts restricted by donors to provide for buildings and movable

equipment should be used to reduce the designated building and movable equipment capital needs, as appropriate.

(3) If a hospital has restricted funds which could be used for a building or equipment purchase but chooses instead to use borrowed money, all costs associated with paying off the incurred debt should not be considered reasonable unless the hospital demonstrates that the financing method used was to the economic benefit of patients then utilizing that building or equipment.

(4) If funds are restricted to a particular type of plant capital project, which is not a replacement of a previous or existing project, these funds should not be used until the hospital has obtained a certificate of need, if required, for that type of plant capital project.

(5) If funds or the income therefrom are restricted to the provision of charity care, these funds or their income should be annually budgeted to offset charity care requirements prior to the budgeting of the use of any patient-generated revenue for charity care for any accounting period.

(6) Funds restricted to research should be used if needed and available to offset any research costs. Patient revenues from revenue cost centers should not be used to provide matching monies for non-patient-care related research.

b. Unrestricted funds from non-patient sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital.

c. Auxiliary enterprises. Profits from such enterprises operated by hospitals should be used primarily to offset the financial requirements of a hospital. Such enterprises should be self-sufficient and profitable. Any losses incurred by the hospital due to such an enterprise which can be demonstrated to be a fringe benefit to hospital employees or of direct economic benefit to patients receiving care during the period of incurred loss may be included in rates.

d. Special projects income. Income received to finance special projects or salaries paid to special project employees should be deducted from financial requirements before determining the amount of payment to be made for patient services. Income to the hospital from the special projects in excess of the projects' financial requirements should be used to offset the hospital's financial requirements.

e. Income from sources other than patients used as offsets to rates should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs. If such a condition should result, the offsets should be adjusted to that portion which would not cause this condition.

3. Variations from budgeted volumes of activity and service. Changes in rates may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.

a. If a hospital over-projects its volume in a service center, in the next year its financial requirements should be increased by an amount equal to the percentage of (fixed) costs for that service center and multiplied by the income loss due to unrealized activity.

b. If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the percentage of (fixed) costs of that service center and multiplied by the budgeted income of that service center.

4. Excess capacity. For hospitals with occupancy rates below the average occupancy rate of other hospitals determined by the system to share common characteristics, rates set on the basis of costs may produce unreasonable charges to patients. The system may assess the rates of such hospitals where the criteria of need for beds shall be consistent with the demand for beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect hospital rates, the hospital shall be considered to have excess capacity.

a. Prior to any determination by the system that excess capacity exists in a hospital, the system shall submit its preliminary determination to the appropriate health systems agency and to the State Health Planning and Development Agency, both of which are identified according to Public Law 93-641, § 1515 and § 1521. These agencies may comment to the system regarding the consistency of this preliminary determination with health planning standards regarding occupancy rates.

b. If these agencies comment that this preliminary determination is consistent with health planning standards and, if applicable, the declarations of an appropriateness review, then the system may determine a hospital to have excess capacity. This determination shall state in quantitative terms the extent of any determination of excess capacity and the basis for the determination.

c. In hospitals where excess capacity exists, the

annual inflation factor and any debt principal payment to the plant capital fund which relates to beds, in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1), should be reduced by the proportion of excess beds to total beds available.

B. Investigations.

1. The system may investigate any or all hospital rates, rate components or rate structures established by a hospital or common to more than one hospital. Such investigations shall be supplemental to and not in place of review of reports of rate revenue and expense or interim increase reports as authorized by MHD 487 C.2.

2. The system shall investigate the basis of existing rates as contained in the rate revenue and expense reports of hospitals in an effort to assess whether or not current rates are reasonable, equitable, and nondiscriminatory among insurers.

3. The system shall notify any hospital or hospitals whose rates, rate components or rate structures are to be investigated, as provided by (1) or (2) above, and shall state the objective of such an investigation.

4. Investigations and subsequent reports shall analyze rates, rate components and rate structures in accordance with the bases for judging established by MHD 487 A.

5. Investigative report. Subsequent to an investigation, the system shall issue an investigative report which shall detail its findings. The findings of an investigative report shall be considered in the review of any interim increase or rate revenue and expense report subsequently submitted by an investigated hospital.

C. Review of reports.

1. General provisions: completeness.

a. Each report required by these rules shall be reviewed by the system in order to ascertain that the report is complete. A report shall be deemed to be filed when the system has ascertained that the report is complete. Complete means that the report contains adequate data for the system to commence its review in a form determined to be acceptable by the system pursuant to MHD 474 A., MHD 474 B., and MHD 474 C., as appropriate.

b. If the system has not responded to the hospital within ten working days after the receipt of a report by the system, the report is deemed to be complete and filed as of the initial day of receipt by the system. The system may stipulate any additional time it may need to ascertain a report's completeness in which case, the ten working day period does not apply. Such stipulated additional time shall not exceed thirty days after the day of the initial receipt of a report by the system.

c. A report determined by the system to be incomplete shall be returned immediately by the system to the hospital stating the need for more data. The hospital shall resubmit an amended report to the system. Such a return and resubmittal shall be recorded in that hospital's file as maintained by the system. If the resubmitted report is determined to be complete by the system, then it shall be deemed to be filed on the date the resubmitted report is received by the system.

d. Reports filed with the system by hospitals prior to the effective date of this rule shall be deemed to be temporarily complete. Subsequent to the effective date of these rules, the system may require hospitals to amend these reports to conform with the requirements of these rules.

e. If a hospital discovers any error in its statements or calculations in any of its submitted reports ascertained by the system to be complete, it shall inform the system of the error and submit an amendment to a report.

(1) In the case of an interim increase report or a rate revenue and expense report, the submittal of an amended report by a hospital to the system shall not affect the date of filing or the sixty-day period required, providing:

(a) The hospital informs the system of any errors within thirty calendar days of the initial filing of a report; and

(b) The amendment to the report is submitted to the system by a date determined by the hospital and the system to be acceptable.

(2) An amended rate revenue and expense report or interim increase report not meeting the conditions established by MHD 487 C.1.e.(1), above, shall be refiled as if it were a new report.

f. If the system discovers an error in the statements or calculations in a report filed with it which the

system determines will have a noticeable impact upon its ability to render a fair comment on the report, it may:

(1) If the discovery occurs within thirty calendar days after the date of filing of the report, require the hospital to amend and resubmit the report by a date determined by the system and the hospital to be acceptable. The initial filing date is not affected in this instance.

(2) If the discovery occurs thirty calendar days or more after the date of filing of the report, require that the hospital resubmit a new report. The date of filing shall then be the date when the new report is submitted to the system, pending the determination by the system that the new report is complete.

2. Review of rate revenue and expense reports and interim increase reports.

a. These reports shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Statistical and financial information available for a hospital as a whole institution may be compared with the same type of information for other peer hospitals which share common characteristics. In instances where service centers among hospitals sharing common characteristics themselves share common characteristics, hospitals may be compared on a service center basis. Common characteristics may include:

(1) Similarity in available number of beds and related occupancy rates;

(2) Similarity in composition of areas of patient origin;

(3) Similarity in composition of patient services;

(4) The status of a hospital as a teaching or non-teaching institution;

(5) Similarity in size and composition of full-time-equivalent staff of the hospital and ratios of that staff to patient admissions; and

(6) Other data determined by the system to be appropriate which may be available pursuant to annual licensing report requirements as established pursuant to MHD 78 (d)(1).

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public. The comment shall state that a hospital's existing and proposed rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Rates are similar to the average of the rates then in effect for other hospitals in a peer group;

(b) Prospective rates represent a minimal increase which is consistent with the principles of the bases for judging established by MHD 487 A.;

(c) Rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by MHD 487 A.

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Rates deviate from the average of the rates then in effect for other hospitals in a peer group;

(b) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by MHD 487 A.;

(c) Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by MHD 487 A.

D. Public meetings. All official meetings of the system, including executive sessions, which occur for any purpose related to completion of an investigation, release of results of an analysis, or issuance of comment upon review of reports pursuant to these rules shall be open to the public. Public notice shall be given one week in advance of any official meetings of the system where the results of investigations, analyses or reviews are to be discussed or acted upon.

E. Burden of proof. In all matters relating to the review of interim increase reports or rate revenue and expense reports or other analyses or investigations, the burden of proof of the reasonableness, equity and lack of discrimination of established or proposed rates under review shall rest with the hospital.

F. Consolidation. When two or more investigations, analyses or reviews involve common questions of fact, the system may address the common questions of fact and make comments applicable to all hospitals under consideration.

MHD 488-495 Reserved for future use.

MHD 496 Approval for operation of the system. The board may approve the operation of the system by any voluntary, nonprofit rate review organization.

A. Application. Such an organization desiring this approval may apply for approval by the following procedure:

1. Open application period. A voluntary, nonprofit rate review organization may apply for approval of its reporting and review procedures after January 1 and before March 31 of a fiscal year, or within ninety days after the effective date of these rules, for operation of the Minnesota Hospital Rate Review System during the next subsequent fiscal year.

2. Contents of application. An application for approval shall include:

a. A detailed statement of the type of reports and administrative procedures proposed by the applicant which shall demonstrate that, in all instances, the reports and procedures are substantially equivalent to those established by the system, pursuant to MHD 474, MHD 481, and MHD 487.

b. A statement that all reports determined to be complete and information filed with the applicant from its participating hospitals shall be available for inspection by the board and the public within five working days after completeness of reports is proposed to be determined and at least prior to the proposed date of issuance of any findings and comments.

c. Provisions establishing a proposed enrollment period for hospitals which shall not extend beyond March 31 of any fiscal year, or beyond ninety days after the effective date of these rules in the first instance, for any eligible hospital that wishes to participate in the proposed program of the applicant for the next three subsequent fiscal years.

d. Provisions establishing any proposed criteria whereby a hospital may be judged by the applicant to be eligible for participation in its proposed program.

e. Any additional statements or information which is necessary to insure that the proposed reporting and review procedures of the applicant are substantially equivalent to all the rules established for the system, pursuant to MHD 474, MHD 481, and MHD 487.

B. Review of application.

1. Within forty-five calendar days of the receipt of an application for approval by a voluntary, nonprofit rate review organization, the board shall issue its decision that the procedures for reporting and review proposed by the applicant are approved or disapproved. Approval by the board shall take effect immediately.

2. Disapproval. The board may disapprove any application on demonstration that the reporting and review procedures of any voluntary, nonprofit rate review organization are not substantially equivalent to those established by the board.

3. Reapplication. An organization whose application has been disapproved by the board may submit a new or amended application to the board within fifteen calendar days after disapproval of the initial application. An organization may only reapply for approval on one occasion during any fiscal year.

C. Annual review of applicant.

1. By March 31 of each year, any voluntary, nonprofit rate review organization whose reporting and review procedures have been approved by the board for the fiscal year then in progress which desires to continue operation of the system shall submit an annual review statement of its reporting and review procedures.

2. The annual review statement shall include:

a. Attestation by the applicant that no amendments or modifications of practice contrary to the initially approved application have occurred; or,

b. Details of any amendments or modifications to the initially approved application, which shall include justifications for those amendments or modifications.

3. The board may require additional information from the applicant supporting that the applicant's reports and procedures are substantially equivalent to those established for the system.

4. Forty-five days from the receipt of the annual review statement, the board shall issue its decision that the applicant has renewed approval or that the applicant has been denied renewed approval. Renewed approval shall be immediately effective.

5. Denial of renewed approval. The board may

deny renewed approval on the demonstration that the reporting and review procedures of any applicant are no longer substantially equivalent to those established for the system.

6. Reapplication. An applicant whose renewed approval has been denied by the board may submit a new or an amended annual review statement to the board within fifteen calendar days after denial of the initial statement. An applicant may only reapply on one occasion during the fiscal year.

7. A hospital enrolled with an applicant whose renewed approval has been denied and which has not enrolled with any other applicant whose reporting and review procedures have been approved by the board shall become subject to the system as operated by the board for the next three subsequent fiscal years.

D. Revocation of approval. The board may revoke its approval of any applicant's reporting and review procedures at any time upon demonstration that the reporting and review procedures of that organization are no longer substantially equivalent to those required by the system.

MHD 497-503 Reserved for future use.

MHD 504 Board determination of allowable increase limit.

A. The board maintains the authority to establish allowable increase limits. Increases in rates which have minimal impact upon the average charges per patient admission for the hospital are allowed to meet expenses incurred by a hospital due to inflation. Increases are determined to have minimal impact if they do not exceed, for any projected accounting period or portion thereof, a cumulative total of the appropriate quarterly allowable increase limits established by the board.

B. During the quarter of the first fiscal year that these rules are effective, the board shall establish a quarterly allowable increase limit:

1. For each of the full quarter(s) of its current fiscal year which remain unexpired at the time rules are promulgated; and

2. For each quarter of its next subsequent fiscal years necessary to result in a total of six quarterly allowable increase limits corresponding to the next six quarters of the current and next subsequent fiscal years occurring immediately after the implementation of these rules.

C. At the beginning of each quarter subsequent to the effective date of these rules, the board shall establish a quarterly allowable increase limit for the sixth subsequent quarter.

D. The board shall provide each hospital and each approved applicant with information concerning the quarterly allowable increase limits on each occasion that the board does establish such a limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average charges per in patient admission for the hospital.

F. Basis. This single percentage figure is based upon the averaged monthly Consumer Price Index, as published by the Division of Labor Statistics, U.S. Department of Commerce, stated as percent changes, for relevant previous quarters preceding the establishment of a quarterly allowable increase limit.

G. Compensation. Should quarterly allowable increase limits prospectively established by the board according to these rules allow increases in rates in excess or less than any actual increases in the Consumer Price Index, the board may compensate for this excess by:

1. Measuring the difference between the prospective quarterly allowable increase limits and the actual changes in the Consumer Price Index for expired quarters; and,

2. Adding or reducing by a reasonable proportion of that difference the next quarterly allowable increase limit to be established by the board.

H. Exceptions. Increases directly attributable to any of the following causes are allowable, providing the hospital notifies the system by letter at the time of such increases and the exception category under which the increase qualifies and the hospital documents any of these as the causes for increase in rates in its next subsequent report of rate revenue and expense:

1. The base cost and dollar amount of increased costs of malpractice insurance. The hospital shall provide information indicating the effective date of any related premium increases.

2. The increased cost of any government mandated pension funding requirements. The hospital shall indicate the effective date of the related cost increase.

3. The increased cost of salaries, wages, or fringe benefits to employees resulting from labor negotiations. The hospital shall indicate the extent of increased costs.

4. Changes in Federal or State law or regulation

which cause uncontrollable increases in cost. The hospital shall indicate the law or regulation causing change and the nature of the effect of the change upon rates.

5. Changes in rates in acute care beds in hospitals operated by the commissioner of public welfare due to legislative action.

MHD 505-508 Reserved for future use

MHD 509 Fees. Hospitals whose rates are reviewed by the system as operated by the board shall submit filing fees with rate revenue and expense reports and interim increase reports which are submitted to the board. These fees are based on the cost of reviews and the number of beds licensed as acute care beds in a hospital, pursuant to Minn. Stat. §§ 144.50 to 144.58.

A. Rate revenue and expense report fee. On each occasion which a hospital submits a rate revenue and expense report to the system as operated by the board, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

If the Number of Licensed Acute Care Beds of the Hospital is:	Then the Filing Fee Is:
6 to 24	$ 385.00
25 to 49	$ 495.00
50 to 99	$ 710.00
100 to 149	$ 930.00
150 to 199	$1,150.00
200 to 249	$1,370.00
250 to 299	$1,590.00
300 to 349	$1,810.00
350 to 399	$2,025.00
400 to 449	$2,250.00
450 to 499	$2,470.00
500 or over	$2,685.00

B. Interim increase report fee. On each occasion which a hospital submits an interim increase report to the system as operated by the board, it shall accompany this report with a filing fee. This fee shall be one-half of the rate revenue and expense report fee, as established by MHD 509 A., providing the report is timely.

C. "Timely" means that each report has been submitted within the time prescribed by MHD 481 C.1. or MHD 481 D.1., as appropriate, that an extension of these reporting times, as permitted by MHD 481 G., has not been necessary, and that the report has been determined to be complete, pursuant to MHD 487 C.1. If a report does not meet these standards, the board may require the submission of an additional late fee according to the following late fee schedule:

1. A report submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1., as appropriate, for which an extension in time has been permitted, pursuant to MHD 481 G., shall be liable for a late fee in addition to the filing fee established by MHD 509 A. or MHD 509 B., above, as appropriate. This late fee shall be ten percent of the filing fee established by MHD 509 A. or MHD 509 B., above and as appropriate for that hospital.

2. A report submitted by a hospital which is determined not to be complete, pursuant to MHD 487 C.1., shall be liable for a late fee for each occasion on which a resubmission as provided by MHD 487 C.1. occurs. This late fee shall be, for each such occasion of resubmission, five percent of the filing fee paid on submission of the initial report to the board by the hospital as established by MHD 509 A. or MHD 509 B., above.

3. Reports not submitted or submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1., as appropriate, for which an extension has not been requested or permitted, pursuant to MHD 481 G., shall be liable for the cost of a full audit by an independent public accountant, as necessary for the completion of the report in addition to the filing fee established by MHD 509 A. or MHD 509 B., above, as appropriate.

D. The board may suspend all or any portion of the filing fees and late fees herein established upon cause being shown by a hospital. Such cause may consider such factors as:

1. The inability of a hospital to pay the fees without directly affecting the rates.

2. The occurrence of any emergency financial condition of a hospital, including natural disasters or difficulties associated with completion of reports related to sicknesses or other absences of related hospital employees or other administrative complications resulting in delay in the completion of reports.

3. Other factors which relate to the economic condition or administrative condition of a hospital.

MHD 510 Official offices. For purposes of these rules, the official offices of the board are:

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

Minnesota State Board of Health
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

MHD 511 Severability. If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction, or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and the applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

MHD 512-520 Reserved for future use.

Appendix A

Proposed Minn. Rule MHD 471 B. references the normal step-down requirements for allocation of costs under the following Federal regulation:

20 CFR § 405.453 Adequate cost data and cost finding.

(a) Principle. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(b) Definitions — (1) Cost finding. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) Accrual basis of accounting. Under the accrual basis of accounting revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred regardless of when they are paid.

(c) Adequacy of cost information. Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

(d) Cost finding methods. After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual costs of services rendered during that period. However, for reporting periods beginning after December 31, 1971, providers using the Departmental Method of cost apportionment must use the Step-Down Method described in subparagraph (1) of this paragraph or an "Other Method" described in subparagraph (2) of this paragraph under the conditions provided therein. The modified cost finding method provided in subparagraph (3) of this paragraph must be used for reporting periods beginning after December 31, 1971, by providers which are required to use the Combination Method of cost apportionment.

(1) Step-down method. This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) Other methods — (i) The double-apportionment method. The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open," accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in

each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) More sophisticated methods. A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

(3) Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971. This method differs from the Step-Down Method in that services rendered by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue-producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing cost centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional, but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval of the Social Security Administration, based upon a written request by the provider submitted through the intermediary.

(4) Temporary method for initial period. If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the intermediary for permission to use some other acceptable method which would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(e) Accounting basis. The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

(f) Cost reports. For cost reporting purposes, the health insurance program requires each provider of services to submit periodic reports of its operations which generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Social Security Administration.

(1) Cost reports — terminated providers and changes of ownership. A provider which voluntarily or involuntarily ceases to participate in the health insurance program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

(2) Due dates for cost reports. (i) Cost reports are due on or before the last day of the third month following the close of the period covered by the report.

(ii) A 30-day extension of the due date of a cost report may, for good cause, be granted by the intermediary, after first obtaining the approval of the Social Security Administration.

(iii) The cost report from a provider which voluntarily or involuntarily ceases to participate in the health insurance program or experiences a change of ownership is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership.

Appendix B

Proposed Minn. Rule MHD 487 A.1.a.(3)(b) references approved educational activities defined by the following two Federal regulations:

20 CFR 405.116(f)

(f) Medical or surgical services provided by a physician, intern, resident, or resident-in-training. Medical or surgical services provided in a hospital by a physician or by a resident or intern, are excluded from the definition of "in-patient hospital services" unless such services are provided

(1) by an intern or resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association; or (2) in the case of a hospital or osteopathic hospital, by an intern or resident-in-training in the field of dentistry under a teaching program approved by the Council on Dental Education of the American Dental Association; or (3) for cost reporting periods beginning after December 31, 1972, by an intern or resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

20 CFR 405.421(e)

(e) Approved programs. In addition to approved medical, osteopathic, dental, and podiatry internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

Program	*Approving Bodies*
(1) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic Internships	The American Dietetic Association.
(3) Hospital Administration Residencies	Members of the Association of University Programs in Hospital Administration.
(4) Inhalation Therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical Records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical Technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse Anesthetists	The American Association of Nurse Anesthetists.
(8) Professional Nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical Nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for nursing.
(10) Occupational Therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy Residencies	American Society of Hospital Pharmacists.
(12) Physical Therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray Technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

Housing Finance Agency

American Indian Housing

Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held in Conference Room D, Veterans Service Building, Capitol Approach, on January 4, 1977 commencing at 9:30 a.m. and continuing until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted by mail to: George A. Beck, Room 300, 1745 University Avenue, St. Paul, Minnesota, 55104 either before the hearing or within 20 days after the close of the hearing.

The proposed rules, if adopted, would when considered within the framework of the Loan Agreement and Housing Plan set guidelines for the utilization by the Minnesota Chippewa Tribe, the Red Lake Band of Chippewas, the Sioux Communities and other American Indians living in Minnesota of the $5,000,000 appropriation for American Indian Housing made by the Minnesota Legislature by Laws of 1976, ch. 254, § 16. A copy of the proposed rules appears below and one additional free copy may be obtained by writing to the Minnesota Housing Finance Agency, First Floor, Hanover Building, 480 Cedar Street, St. Paul, Minnesota, 55101. Additional copies will be available at the door at the date of the hearing. The Agency's authority to

promulgate the proposed rules is contained in Laws of 1976, ch. 254, § 9. A "statement of need" explaining why the Agency feels the proposed rules are necessary and a "statement of evidence" outlining the testimony they will be introducing will be filed with the Hearing Examiner's Office at least 25 days prior to the hearing and will be available there for public inspection.

Please be advised that pursuant to Minn. Stat. § 10A.01, subd. 11 (1974) any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual.

James F. Dlugosch
Executive Director

Rules as Proposed

Chapter Eight: American Indian Housing

MHFA 90 Scope. Rules 90 to 108 hereof, together with the Loan Agreement (hereinafter the "Agreement"), govern the housing programs for American Indians of low and moderate income as authorized by Laws of 1976, ch. 254 (hereinafter the "Act"), and the disposition of the appropriation made pursuant to § 16 of said Act, which housing programs are to be developed and administered separately or in combination by the Minnesota Chippewa Tribe, which for purposes of these Rules shall include any corporation established by the Minnesota Chippewa Tribe to carry out the housing program provided for herein and by the Act, (hereinafter collectively the "Tribe"), the Red Lake Band of Chippewa Indians, which for purposes of these Rules shall include any corporation established by the Red Lake Band of Chippewa Indians to carry out the housing program provided for herein and by the Act, (hereinafter collectively the "Band") and the Sioux Communities, which for purposes of these Rules shall include any corporation established by the Sioux Communities to carry out the housing program provided for herein and by the Act, (hereinafter collectively the "Communities").

MHFA 91 Development of plan. In developing each such housing program, the Tribe, Band, and Communities shall take into account the housing needs of all American Indians residing both on and off reservations within the state. A plan (hereinafter the "Plan") for each such program, which is in accordance with these rules and which specifically describes the program: content, utilization of funds, administration, and operation and implementation, shall be submitted to the Minnesota Housing Finance Agency (hereinafter MHFA) for its review and approval prior to the making of eligible loans.

MHFA 92 Qualifications for housing. Except as otherwise provided herein and by MHFA 4, each recipient of a loan pursuant to the Act, Plan and these Rules and each person or family occupying a dwelling unit financed pursuant thereto shall be an American Indian as defined by Minn. Stat. § 254A.02, subd. 11, and of low and moderate income as defined by MFA 2(o), provided that developers of multifamily housing developments need not be American Indians or of low and moderate income, and further provided that the Tribe, Band and Communities may qualify as eligible borrowers, if the funds advanced are used to construct eligible housing for resale or rental to eligible recipients and the funds advanced are returned to the revolving loan fund under the jurisdiction of the Tribe, Band or Communities when permanent financing is obtained.

MHFA 93 Adjusted income. Adjusted income shall be computed in accordance with MHFA 2(n). To calculate adjusted income for purposes of this Rule, the applicant's gross annual income for the two years immediately prior to the date of application for the loan, adjusted in accordance with MHFA 2(n), shall be added to the applicant's projected gross annual income for the year next following the date of application, also adjusted in accordance with MHFA 2(n), and the total thus obtained shall be divided by three.

MHFA 94 Refinancing existing loans. No loan shall be approved or disbursed for the purpose of refinancing an existing loan. The Plan may set funding priorities for the types of housing loans to be made based upon housing need considerations.

MHFA 95 Limit on sale price or appraisal value. Each plan submitted to MHFA for approval shall provide for a maximum limitation on the sale price or appraised value, whichever is greater, of a structure or structures designed primarily for residential use by not more than four families, or a dwelling in a planned unit development or a condominium. No loan for rehabilitation of any property shall be made in an amount which, when added to all other existing indebtedness secured by the property, would exceed its market value as determined by a qualified appraiser.

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

MHFA 96 Duration of loan. No loan shall be made for a term in excess of thirty (30) years on a structure or structures designed for occupancy by not more than four families, or a dwelling unit in a planned unit development or a condominium. The maximum term of a rehabilitation loan for an existing structure or structures designed for occupancy by not more than four families or a dwelling unit in a planned unit development or a condominium shall not exceed twelve (12) years. For all other residential structures, the maximum term of any loan including a rehabilitation loan, granted pursuant to the Act, Plan and these Rules shall not exceed forty (40) years.

MHFA 97 Security for loans. Each plan submitted to MHFA for approval shall specify the means by which loans made pursuant to the Plan and these Rules are to be secured.

MHFA 98 Rate of interest. The rate of interest charged by the Tribe, Band or Communities on housing loans made pursuant to the Act, the Plan and these Rules, shall be not less than 2% and not more than the highest rate of interest authorized by applicable usury and lending laws. The prime consideration in establishing rates of interest for eligible loans shall be to make the Plan self-supporting by generating sufficient interest income to offset the expenses incurred in the development and operation of the Plan, with the exception of the first year's expenses which shall be funded from the appropriation provided in the Act upon MHFA's approval of a detailed budget for that first year.

MHFA 99 Remunerating MHFA. The Agreement shall provide the circumstances under which MHFA shall provide assistance to the Tribe, Band or Communities and the amount of remuneration to be received by MHFA from the Tribe, Band and Communities for its assistance and monitoring.

MHFA 100 Revolving housing fund. The Tribe, Band and Communities shall repay to MHFA, without interest, all funds advanced to it pursuant to the Agreement to the extent and in the manner provided in the Agreement.

MHFA 101 Credit rating. Each Plan submitted to MHFA for approval shall contain adequate means for determining that the eligible borrower is an acceptable credit risk.

MHFA 102 Audit by legislative auditor. All of the official books and records of the Tribe, Band, and Communities relating to the housing program shall be subject to audit by the Legislative Auditor in the manner prescribed for agencies of state government as required by the Act.

MHFA 103 Final decision on loans. Each final decision on applications for loans to eligible borrowers made by the Tribe, Band or Communities from the moneys appropriated by § 16 of the Act, or from the revolving loan fund under the jurisdiction of the Tribe, Band, or Communities, shall be made by a representative body of the Tribe, Band, or Communities.

MHFA 104 Duties of originator. The Tribe, Band and Communities shall each provide information on their respective Plans to eligible borrowers, receive and process loan applications, provide MHFA with a summary of the applications to be funded on a form provided by MHFA and establish lending procedures which comply, to the extent applicable, to the Real Estate Settlement Procedures Act, Truth-in-Lending legislation, and applicable usury and other lending laws. The Tribe, Band and Communities shall service or cause to be serviced all loans made by them to eligible borrowers. The provisions regarding servicing shall be detailed in the respective Plans and shall outline all servicing responsibilities including, but not limited to, composition and retention of loan files, escrow accounts, reporting systems, handling of delinquencies, and default and foreclosure policies and procedures. To the extent that the Tribe, Band or Communities enter into housing programs with the Department of Housing and Urban Development (hereinafter "HUD") the Tribe, Band or Communities shall be relieved of the applicable obligations imposed by this Rule if such obligations are assumed by HUD or otherwise discharged in a manner acceptable to MHFA.

MHFA 105 Building code. All authorized construction funded by an eligible loan and accomplished pursuant to an approved Plan shall conform to the uniform building code of the State of Minnesota and all applicable federal regulations, rules or codes. Each plan submitted to MHFA for approval shall contain a means of inspection to insure that any such authorized construction conforms to the applicable building code.

MHFA 106 On and off reservation. Each Plan shall provide for a reasonable balance in the distribution of funds between American Indians residing on and off reservations within the state, as shown by evidence contained in the Plan concerning on and off reservation population, percentage of low and moderate income American Indians, delivery capabilities and similar circumstances. The Plan may provide that at the option of the Tribe, Band or Communities, the origination and servicing of loans to eligible recipients residing off the reservation may, by separate agreement, be performed by a party or parties selected by the Tribe, Band or Communities.

MHFA 107 Fees and charges. The fees and charges to be paid by an eligible borrower in connection with the mak-

ing of an eligible loan shall be determined by the Tribe, Band and Communities and specified in the Plan; provided, that if MHFA or its agent originate and service or cause to be serviced eligible loans for qualified borrowers residing off reservations pursuant to MHFA 106, above, MHFA shall determine as to those loans the reasonable fees and charges to be paid to MHFA and/or its agent, in an amount not to exceed the amount authorized by law.

MHFA 108 Rights of MHFA. MHFA shall have the right to inspect, copy or abstract, at reasonable times and upon three days notice, all books, records, papers, or any other documents relating to the Plan, or loans made pursuant thereto, or any funds held in a revolving loan fund under the jurisdiction of the Tribe, Band or Communities for the purpose of making eligible loans.

KEY: New rules and material proposed to be added to an existing rule are printed in **boldface.** Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

OFFICIAL NOTICES

EQC Monitor Environmental Quality Council

Actions taken at the November 9, 1976 EQC Meeting

1. In the matter of MP&L-TR-1A (500 kV*transmission line from Kettle River to Forbes), accepted as of November 15, 1976, a route construction application from MP&L*, adopted a charge to that Route Evaluation Committee, and ordered preparation of an Environmental Impact Statement (EIS).

2. Determined the Environmental Assessment (EA) on the Metropolitan Waste Control Commission sludge facility is adequate and no EIS is required.

3. Determined the Environmental Assessment Worksheet (EAW) on Plymouth Reservoir #4 is adequate and no EIS is required.

4. Determined the EA on Amesbury II residential development in Deephaven is adequate and no EIS is required.

5. Determined the EAW on West Publishing Company proposed warehouse and manufacturing facility in Eagan is adequate and no EIS is required.

6. Determined no environmental review need be ordered on the Koch Refining Barge Terminal expansion.

7. Determined no environmental review need be ordered at this time on the Green Lake sewer district.

8. Determined the 3M Final EIS is adequate.

9. Determined the Edenvale Final EIS is inadequate and designated the City of Eden Prairie as responsible agency.

10. Adopted EIS rules to be sent to Hearing Examiner and Attorney General for approval.

11. Determined legislative recommendations relating to pesticides should be tabled until further details on programs are available.

*MP&L — Minnesota Power and Light Company
kV — kilovolt

(End of EQC Monitor)

Minnesota State Retirement System

Notice of Special Meeting

The Board of Directors, Minnesota State Retirement System, will hold a special meeting on Friday, December 3, 1976, at 9:00 A.M. in the office of the System, 529 Jackson Street, St. Paul, Minnesota.

STATE OF MINNESOTA
OFFICE OF THE STATE REGISTER
95 Sherburne, Suite 203
St. Paul, Minnesota 55103

SUBSCRIPTION ORDER FORM

$110.00—annual subscription to the *State Register* (53 issues)

SAVE MONEY ON ADDITIONAL SUBSCRIPTIONS:

$85.00—second subscription and additional subscriptions (each)

I would like _____ subscriptions at a total cost of $_____. I have enclosed that amount in a check or money order made out to: "Minnesota State Treasurer."

Name of Company or Organization _____

Attention to: _____

Street _____

City _____ State _____ Zip _____

Telephone _____

NOW AVAILABLE:
STATE REGISTER BINDERS

3½ Inch Durable Plastic Self-locking Binders

STATE OF MINNESOTA
OFFICE OF THE STATE REGISTER
95 Sherburne, Suite 203
St. Paul, Minnesota 55103

BINDER ORDER FORM

$5.00 *State Register* Binder

I would like _____ binder(s), at a total cost of $_____. I have enclosed that amount in a check or money order made out to: "Minnestoa State Treasurer."

Name of Company or Organization _____

Attention to: _____

Street _____

City _____ State _____ Zip _____

Telephone _____

House of Representatives
Attn: Edward Burdick, Chief Clerk
Room 211 Capitol
St. Paul, Minnesota 55155