DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

MAY 17 2012

Mr. David Godfrey
State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55164-0983

RE: Minnesota State Plan Amendment (SPA) 11-26

Dear Mr. Godfrey:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-26. Effective for services on or after October 1, 2011, this amendment revises methodology for making payments for nursing facility (NF) services. Specifically, with this amendment applications will no longer be accepted for planned closure rate adjustments; automatic licensing fee and inflation rate adjustments are suspended; facilities located within one quarter mile of a geographic peer group with a higher limit are given the operating payment rate of the nearest nursing facility in the geographic peer group with the higher limit; the operating payment rate is increased for low rate NFs; further steps to rebase operating payment rates are repealed.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 11-26 is approved effective October 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (608) 441-5344.

Sincerely,

Cindy Mann,
Director (CMCS)

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-26

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §447.252

7. FEDERAL BUDGET IMPACT (in thousands)
a. FFY '12: $71
b. FFY '13: ($370)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-D (Non-State Government-Owned or Operated NF), pp.1-~~188~~ 185

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-D, pp. 1-~~187~~ 184

10. SUBJECT OF AMENDMENT:
Methods and Standards for Determining Payment Rates for Services Provided by Nursing Facilities

11. GOVERNOR'S REVIEW *(Check One)*:
X GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ann Berg

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
November 21, 2011

16. RETURN TO:
Lisa Knazan
Minnesota Department of Human Services
Federal Relations Unit
PO Box 64983
St. Paul, MN 55164-0983

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 17 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:
Pen and ink changes to lines #8 & 9

FORM HCFA-179 (07-92)

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY NURSING FACILITIES (NOT STATE GOVERNMENT-OWNED OR OPERATED)

INDEX

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY NURSING FACILITIES (NOT STATE-GOVERNMENT OWNED OR OPERATED)

SECTION 1.000 INTRODUCTIONS

SECTION 1.010 **General Purpose.** The purpose of the Minnesota Medicaid methods and standards for determining payment rates for nursing facilities, which are not owned or operated by the state, is to provide for payment of rates in conformity with applicable state and federal laws, regulations and quality and safety standards. In determining the rates, the Commissioner of the Department of Human Services will take into account the mix of resident needs, geographic location, and other factors. Minnesota has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

Through September 30, 2006, nursing facilities participating in the Minnesota Medical Assistance program could choose to be paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or the contractual rate-setting methodology described in Section 22.000. Effective October 1, 2006, all nursing facilities were paid by the contractual rate-setting methodology described in Section 22.000. Effective October 1, 2008, nursing facilities are paid by a combination of the contractual rate-setting methodology in Section 22.000 and a new rebasing rate-setting methodology described in Section 23.000.

SECTION 1.020 Overview. A very brief description of the overall rate setting mechanism may be helpful. Cost reports are submitted annually. Nursing facilities have a common reporting year of October 1 to September 30. The rate year of October 1 to September 30, lags the report year by one year. The submitted cost reports are desk audited to determine allowable costs and then subject to various other cost category limitations. The rates that are set are subject to appeal. Rates may be adjusted retrospectively for field audit and appeal resolutions. Nursing facilities in

Minnesota cannot charge private paying residents rates which exceed the rate for medical assistance recipients receiving similar services in multiple bed rooms. The rate-setting systems can be summarized as follows:

A. **Care Related Costs Until July 1, 1999**

1. This type of cost is based on allowable care related costs from prior reporting years for each nursing facility. Only the nursing component varies with a resident's case mix.

2. Resident days and nursing care costs are adjusted using case mix weights to determine proportion of costs allocable to each of eleven payment classes.

3. There are eleven rates for each nursing facility based on the relative resource use and case mix needs of the resident.

4. Until July 1, 1999, homes are grouped by three geographic locations which set limits on rates. Special purpose or characteristic homes may be treated differently for purposes of applying rate limits.

5. Homes can also trade off nursing and other care related expenditures within the combined limits for those two cost categories. Beginning July 1, 1998, these two limitations do not apply, except for purposes of determining a facility's efficiency incentive.

6. The care related costs include nursing salaries and supplies and non-prescription drugs.

7. The other care related costs include food costs, social services, activities etc.

B. **Overall Spending Limits Until July 1, 1999**

1. Pursuant to Section 11.047, the operating rate paid to a nursing facility will not be more than its prior year's allowed operating costs plus inflation plus a factor above inflation (on a per diem basis).

2. Pursuant to Section 11.047, a nursing facility determined to be high cost when compared to similar nursing facilities shall have its per diem costs reduced.

C. **Other Operating Costs Until July 1, 1999**

1. These costs are grouped by geographic location to set limits. Beginning July 1, 1998, nursing and other care related expenditures do not apply, except for purposes of determining a

facility's efficiency incentive. Similarly, the maintenance and administrative cost categories no longer apply.

2. There is an efficiency incentive. Homes can receive an additional payment if costs are under the Other Operating Cost limit.

3. The other operating costs include such costs as remaining dietary, laundry and linen, housekeeping, plant operations and maintenance, general and administrative, and the remaining payroll taxes and fringe benefits.

D. **Adjustment Factor**

1. Until July 1, 1999, all operating costs are updated annually by a 21 month inflation factor. The 21 month inflation factor accounts for the 9 month lag between the end of the reporting year (9/30) and the beginning of the rate year (the following 7/1). The Department contracts with an econometric firm to provide economic change indices for use in determining operation cost payment rates.

2. Until July 1, 1999, limits are established for a base year and are adjusted annually by a 12 month inflation index for the time period between the midpoints of cost reporting years. The process of indexing limits now extends to the overall spending limits.

3. Certain costs such as real estate taxes, special assessments, licensing fees, Public Employee Retirement Act pension contributions, and preadmission screening fees are passed through.

E. **Property Payment**

1. For the period July 1, 1992, to September 30, 1992, property rates continued as established under the current plan; that is, they will continue to be "frozen" with certain exceptions.

2. After September 30, 1992, a new property system took effect. That system establishes a minimum property rate equal to the greater of their current "frozen" property-related payment rate or $4.00 per resident day. This rate may be subject to adjustment due to several factors which include:

a. An incremental increase as determined utilizing the State's former rental system with certain modifications such as a higher equipment allowance, adding the actual cost of a major projects with the application of a limit on investment, or the sale of the nursing facility.

b. An equity incentive payment which will encourage equity rather than debt

financing of major projects. (effective 7/1/93)

c. A capital asset repair or replacement payment for purchases up to $150 per licensed bed per year with a carryover of any excess. (effective 7/1/93)

d. A refinancing incentive for a refinancing that saves on annual interest expense payments (effective 7/1/93).

3. For sales occurring before October 1, 2005, the sale of a nursing facility after June 30, 1992, may result in an increase in the nursing facility's property rate. The amount of that increase will be measured by the modified rental recalculation. An increase in interest expense is allowed within certain limitations. The amount of the "step-up" in the nursing facility's capital asset basis, if any, does not result in a property rate increase since depreciation is not a component of property rate computation.

4. After September 1, 1992, nursing facility appraisals will no longer be needed except to resolve appraisal appeals. The nursing facility's appraised value will be indexed for inflation annually. Also, capital asset additions or deletions will be deducted from the indexed appraised values.

F. **Contractual Rate-setting Alternative Method After August 1, 1995**

1. A nursing facility may apply to be paid a contractual alternative payment rate instead of the cost-based payment rate established under Sections 1.000 to 21.000. Proposal requirements, selection criteria, limits, exemptions, and consumer protections are described in Section 22.000.

2. A nursing facility electing to receive an alternative payment rate must enter into a contract with the Department. All contracts entered into are for a term not to exceed four years.

3. Different contract provisions may be negotiated for different facilities if required due to legislative changes or if negotiated based on facility proposals.

4. A nursing facility's case mix payment rates for the first rate year of a facility's contract is the payment rate the facility would have received under Sections 1.000 to 21.000.

5. Until July 1, 1999, a nursing facility's case mix payment rates for the second and subsequent years of a facility's contract are the previous rate year's contract payment rates plus an inflation adjustment.

6. A Medicare certified nursing facility electing to receive an alternative payment rate filing a Medicare cost report must comply with Section 22.080, item A. A nursing facility that is not Medicare certified does not have to file a Medicare cost report, but must file a cost report as

described in Section 2.000.

7. Certain other exemptions, such as an exemption from auditing requirements under applicable state laws, are outlined in Section 22.000.

8. Participation in the contractual alternative payment rate setting method is voluntary. Participating facilities must continue to comply with all state and federal requirements relating to quality assurances, vulnerable adults protections, residents' rights, and OBRA requirements.

G. Rebasing

Effective October 1, 2008, the nursing facility rate methodology was changed to phase in a new payment system. The rebasing law considers costs, establishes definitions, distinguishes between facility types and peer (or geographic) groups with consideration of facilities in different peer groups but in close proximity, sets limits on spending that can be recognized in the rates, incorporates new case mix indices, rewards efficiency, provides for pass-through of certain costs, and provides that the total payment rate will consist of operating, external fixed, and property payment rates. The new system will be phased in over eight years.

SECTION 1.030 **Definitions.**

Actual allowable historical operating cost. "Actual allowable historical operating cost" means the operating costs incurred by the nursing home and allowed by the Commissioner for the most recent reporting year.

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

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

Appraised value. "Appraised value" means the value of the nursing home buildings, attached fixtures, and land improvements used directly for resident care as determined under Section 17.000.

Assessment form. "Assessment form" means the form developed by the Department of Health as adopted and used for performing resident assessments.

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

guidelines.

Buildings. "Buildings" means the physical plant used directly for resident care and licensed and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the site if used directly for resident care. This definition does not include buildings or portions of buildings used by central, affiliated, or corporate offices.

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

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

Case mix operating costs. "Case mix operating costs" means the operating costs listed in Section 6.050 and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category under Section 8.000.

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

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

B. The construction contracts were let.

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

D. All zoning and building permits have been issued.

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

Commissioner. "Commissioner" means the Commissioner of the Minnesota Department of Human Services.

Consulting agreement. means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel recommend, or suggest to the owner or operator of the nonrelated

long-term care facility measures and methods for improving the operation of the facility.

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

Cost report. "Cost report" means the document and supporting material specified by the Commissioner and prepared by the nursing home. The cost report includes the statistical, financial, and other relevant information for rate determination.

Deletion. "Deletion" means the sale, destruction, or dismantling of a nursing home capital asset or a portion of a nursing home capital asset without subsequent replacement.

Department. "Department" means the Minnesota Department of Human Services.

Depreciated replacement cost method. "Depreciated replacement cost method" means the method of property appraisal which determines the value of a capital asset by establishing the replacement cost new reduced by depreciation.

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

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

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

Depreciation guidelines. "Depreciation guidelines" means the most recent "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois. Except as provided in Section 3.040, the useful lives in the depreciation guidelines must not be used in the determination of the total payment rate. The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota, 55155.

Desk audit. "Desk audit" means the establishment of the payment rate based on the Commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the

nursing home.

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

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

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

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

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

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

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

General and administrative costs. "General and administrative costs" means the costs of administering the nursing home as specified in Section 6.000.

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

Hospital-attached nursing home. "Hospital-attached nursing home" means a nursing home which is: 1) under common ownership and operation with a licensed hospital and shares with the hospital the cost of common service areas such as nursing, dietary, housekeeping, laundry, plant operations, or administrative services; 2) is recognized by the Medicare Program as a hospital-based nursing facility; and 3) is required to use the stepdown method of allocation by the Medicare program, title XVIII of the Social Security Act, provided that the stepdown results in part of the cost of the shared areas to be allocated between the hospital and the nursing home, and that the stepdown numbers are

the numbers used for Medicare reimbursement, except that direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

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

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

Management agreement. Is an agreement in which one or more of the following criteria exist:

A. The central affiliated, or corporate office has or is authorized to assume day-to-day operation control of the long-term care facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the facility to perform or refrain from performing certain acts, or to supplant or take the place to the top management of the facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the facility;

B. The central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the facility board of directors;

C. The central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

D. The agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the facility;

E. The long-term care facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

Medical plan of care. "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment

and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Moratorium exception: A "moratorium exception" results when nursing facilities are permitted to obtain licensure and medical assistance certification of new nursing home beds and construction projects that exceed the threshold in section 16.1374, item F. contingent upon appropriation of funds by the legislature. Appropriated funds are distributed through a competitive process. Rates for moratorium exception projects are determined as stated in section 22.061.

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

Nursing facility. "Nursing facility" means a facility licensed by the Department of Health as a Medical Assistance nursing home or a boarding care facility which meets federal certification requirements for a nursing facility.

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

A. nursing, including nurses and nursing assistants training;

B. dietary;

C. laundry and linen;

D. housekeeping;

E. plant operation and maintenance;

F. other care-related services;

G. general and administrative;
H. payroll taxes, fringe benefits, and clerical training;

I. workers' compensation self-insurance;

J. group health, dental, or life insurance; and

K. real estate taxes and actual special assessments paid.

Other care-related operating costs. "Other care-related operating costs" means the operating costs listed in Section 6.060, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the dietician consulting fees calculated under Section 8.000.

Other operating costs. "Other operating costs" means the operating costs listed in Sections 6.010-6.040 and 6.070, excluding the cost of food and dietician consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under Section 8.000.

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

Preopening costs. "Preopening costs" means the operating costs incurred prior to the admission of a resident to a newly-constructed nursing home.

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

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

Rate year. "Rate year" means the state of Minnesota's fiscal year for which a payment rate is effective, from July 1 through the following June 30. The July 1, 2004 rate year extends through September 30, 2005. As of October 1, 2005, "rate year" means October 1 through the following September 30.

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

Related organization. "Related organization" means a person that furnishes goods or services to a nursing home and that is a close relative of a nursing home, an affiliate of a nursing home, a close relative of an affiliate of a nursing home, or an affiliate of a close relative of an affiliate of a nursing home.

A. An "affiliate" is a person that directly, or indirectly through one or more

intermediaries, controls, or is controlled by, or is under common control with another person.

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

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

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

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

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

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

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

Resident class. "Resident class" means each of the 11 categories established in Section 13.000.

Short length of stay facility. "Short length of stay facility" has the meaning given in Section 20.025.

Standardized resident days. "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class.

Top management personnel. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators and the nursing home administrator, and any other person performing the function of such personnel. Persons performing functions only as nursing home department heads are not included in this definition.

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

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

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

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

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

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

SECTION 2.000

SECTION 2.010
Treble Damages. Any vendor of medical care who willfully submits a cost report, rate application or claim for reimbursement for medical care which the vendor knows is false representation and which results in the payment of public funds for which the vendor is ineligible shall, in addition to other provisions of Minnesota law, be subject to an action by the State of Minnesota for civil damages. The damages awarded shall include three times the payments which result from the false representation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent.

SECTION 3.000 COST ALLOCATION PROCEDURES

SECTION 3.010 **Classification.** Classification of costs is the process of charging costs to the appropriate cost categories and compiling a total for each cost category to be recorded on the cost report. Nursing facilities shall classify their costs in accordance with established cost categories. Costs that cannot be specifically classified in a cost category, such as the cost of generic supplies, must be classified in the general and administrative cost category.

SECTION 3.020 **Identification.** Except for the salary costs of individuals with multiple duties, costs must be directly identified, without allocation, by routine classification of transactions when

costs are recorded in the books and records of the nursing facility.

SECTION 3.030 **Personnel with multiple duties.** When a person other than top management personnel has multiple duties, the person's salary cost must be allocated to the cost categories on the basis of time distribution records that show actual time spent, or an accurate estimate of time spent on various activities. In a nursing facility of 60 or fewer beds, part of the salary or salaries of top management personnel may be allocated to other cost categories to the extent justified in time distribution records which show the actual time spent, or an accurate estimate of time spent on various activities. A nursing facility that chooses to estimate time spent must use a statistically valid method. Persons who serve in a dual capacity, including those who have only nominal top management responsibilities, shall directly identify their salaries to the appropriate cost categories. The salary of any person having more than nominal top management responsibilities must not be allocated.

SECTION 3.040 **Central, affiliated, or corporate office costs.** Cost allocation for central, affiliated, or corporate offices shall be governed by items A to F.

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

1. Definitions. For purposes of item B, the following have the meaning given them.

a. "Management agreement" means an agreement in which one or more of the following criteria exist:

i. The central, affiliated, or corporate office has or is authorized to assume day-to-day operation control of the long-term care facility for any six-month period within a 24-month period. "Day-to-day operation control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the long-term care facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the long-term care facility. Day-to-day operational control includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the long-term care facility;

ii. The central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the long-term care facility to use the group or volume purchasing services of the central, affiliated, or corporate office;

or the authority to make annual capital expenditures for the long-term care facility exceeding $50,000 or $500 per licensed bed, whichever is less, without first securing the approval of the long-term care facility board of directors;

iii. The central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

iv. The agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the long-term care facility; or

v. The long-term care facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

b. "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated long-term care facility measures and methods for improving the operations of the long-term care facility.

B. For rate years beginning on or after July 1, 1990, the central, affiliated or corporate office cost allocation in subitems (1) to (6) must be used when determining rates under Sections 1.000 through 22.000.

(1) All costs that can be directly identified with a specific nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that nursing facility.

(2) All costs that can be directly identified with any other activity or function not described in subitem (1) must be allocated to that activity or function.

(3) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs to the nursing facilities or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the nursing facilities. Where practical and when the amount is material, these costs must be allocated on a functional basis. The functions, or cost centers used to allocate central office costs, and the unit bases used to allocate the costs, including those central office costs allocated according to subitem 4, must be used consistently from one central office accounting period to another. If the central office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the central office must make a written request, with its justification, to the commissioner for approval of the change no later than 120 days after the

beginning of the central office accounting period to which the change is to apply. The commissioner's approval of a central office request will be furnished to the central office in writing. Where the commissioner approves the central office request, the change must be applied to the accounting period for which the request was made, and to all subsequent central office accounting periods unless the commissioner approves a subsequent request for change by the central office. The effective date of the change will be the beginning of the accounting period for which the request was made.

(4) After the costs that can be directly identified according to subitems (1) and (2) have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs, determined as follows:

a. The numerator for the allocation ratio shall be determined as follows:

i. For nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by each related organization or controlled nursing facility.

ii. For a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by the non-nursing facility related organizations.

iii. For a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central affiliated or corporate costs or the contracted amount.

iv. For business activities that involve the providing of goods or services to unrelated parties which are not nursing facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the facility or function.

b. The denominator for the allocation ratio is the sum of the numerators in clauses i to iv of a.

(5) Those long term care operations that have nursing facilities both in Minnesota and outside of Minnesota must:

a. Allocate the nursing facility operation's central, affiliated or corporate office costs identified in item C to Minnesota based on the ratio of total resident days in Minnesota nursing

facilities to the total resident days in all facilities.

b. Allocate the Minnesota nursing facility operation's central, affiliated or corporate office costs identified in a to each Minnesota nursing facility on the basis of resident days.

(6) This section does not apply to payment rates determined under Section 20.040, except that any additional directly identified costs associated with the Department of Human Services' or the Department of Health's managing agent under a receivership agreement must be allocated to the facility under receivership, and are nonallowable costs to the managing agent on the facility's cost report.

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

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

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

(2) the depreciation guidelines.

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

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

SECTION 3.050 **General and administrative costs.** Except as provided above, general and administrative costs must not be allocated as direct or indirect costs to other cost categories.

SECTION 3.060 **Related organization costs.** Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization may be included in the allowable cost of the nursing facility at the purchase price paid by the related

organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, or capital assets, or supplies. The cost of ownership of a capital asset which is used by the nursing facility must be included in the allowable cost of the nursing facility even though it is owned by a related organization.

SECTION 4.000 DETERMINATION OF ALLOWABLE COSTS

SECTION 4.010 **Allowable costs.** Only costs determined to be allowable under the methods used to determine payment shall be used to compute the total payment rate for nursing facilities participating in the medical assistance program.

SECTION 4.020 **Applicable credits.** Applicable credits must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost. Interest income, dividend income, and other investment income of the nursing facility or related organization are not applicable credits except to the extent that the interest expense on working capital debt is incurred and claimed as a reimbursable expense by the nursing facility or related organization. Interest income must not be offset against working capital interest expense if it relates to a bond sinking fund or a restricted fund if the income is not available to the nursing facility or related organization. Gains or losses on the sales of capital assets used by the nursing facility must not be applicable credits.

SECTION 4.030 **Adequate documentation.** A nursing facility shall keep adequate documentation.

A. In order to be adequate, documentation must:

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

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

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

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

(5) Be retained by the nursing facility to support the five most recent annual cost reports. The Department may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices, the records are necessary to resolve a pending appeal, or are required for the enforcement of Minnesota's conditions for participation.

(6) Beginning July 1, 1998, payroll records supporting compensation costs claimed by long-term care facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subitem are met when documentation is provided under either clause a or b as follows:

a. the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

b. if the affirmative time and attendance records identifying the individual's name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are placed on microfilm, equipment must be made available for viewing and printing them, or if the records are stored as automated data, summary data must be available for viewing and printing.

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

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

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

E. If the Commissioner requests supporting documentation during an audit for an item of cost reported by a long-term care facility, and the long-term care facility's response does not adequately document the item of cost, the Commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This provision shall not diminish the long-term care facility's appeal rights.

SECTION 4.040 **Compensation for personal services.** Compensation for personal services includes all the remuneration paid currently, accrued or deferred, for services rendered by the nursing facility's owners or employees. Only valid compensation costs for the current reporting period are allowable.

A. Compensation includes:

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

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

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

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

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

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

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

C. Only necessary services shall be compensated.

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

SECTION 4.050 **Licensure and certification costs.** Operating costs of meeting the licensure and certification standards in items A to C are allowable operating costs for the purpose of setting nursing facility payment rates. The standards are:

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

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

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

SECTION 4.060 **Routine service costs.** Operating costs of routine services including nursing, dietary, and support services are allowable operating costs for the purpose of setting nursing facility payment rates.

SECTION 4.080 **General cost principles.** For rate-setting purposes, a cost must satisfy the following criteria:

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

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

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

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

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

not allowable.

SECTION 5.000 NONALLOWABLE COSTS

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

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

B. Salaries and expenses of a lobbyist.

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

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

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

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

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

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

I. Costs of activities not related to resident care such as flowers or gifts for employees or owners, employee parties, and business meals except for the cost of meals incurred as a result of required overnight business related travel.

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

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

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

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

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

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

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

Q. Bad debts and related bad debt collection fees except for the four types found in the general and administrative services section.

R. Costs of fund raising activities.

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

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

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

V. Telephone, television, and radio service provided in a resident's room except for these services provided in areas designated for use by the general resident population, and the charge of transferring a resident's phone from one room to another within the same nursing facility.

W. Costs of covenants not to compete.

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

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

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

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

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

Y. Costs for which adequate documentation is not maintained or provided.

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

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

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

CC. Payments made in lieu of real estate taxes, unless such payments are made under a legally enforceable irrevocable written contract entered into prior to August 31, 1983.

DD. Adverse judgments, settlements, and repayments of escrow accounts resulting from the enforcement of Minnesota's Conditions for Participation Statute.

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

SECTION 6.000 REPORTING BY COST CATEGORY

SECTION 6.010 **Dietary services.** The costs listed in items A to D are to be reported in the dietary services cost category:

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

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

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

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

SECTION 6.020 **Laundry and linen services.** The costs listed in items A and B are to be reported in the laundry and linen services cost category:

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

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

SECTION 6.030 **Housekeeping services.** The costs listed in items A and B are to be reported in the housekeeping services cost category:

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

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

SECTION 6.040 **Plant operation and maintenance services.** The costs listed in items A to D are to be reported in the plant operations and maintenance cost category:

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

B. The salaries and wages of the supervisor, engineers, heating-plant employees,

independent contractors, and other maintenance personnel:

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

D. Cost of the provider surcharge.

SECTION 6.050 **Nursing services.** Direct costs associated with nursing services identified in items A to Y, are to be included in the nursing services cost category:

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

B. Bedside care and services;

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

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

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

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

G. Prevention of skin irritation and decubitus ulcers;

H. Routine changing of dressings;

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

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

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

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

M. Administration of oxygen;

N. Use of nebulizers;

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

P. Administration of parenteral medications, including intravenous solutions;

Q. Administration of tube feedings;

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

S. Care of suprapubic catheters and urethral catheters;

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

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

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

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

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

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

SECTION 6.060 **Other care-related services.** The costs listed in items A to D are to be reported in the other care-related services cost category:

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

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

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

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

SECTION 6.070 **General and administrative services.** Direct costs for administering the overall activities of the nursing facility are included in the general and administrative cost category. These direct costs include:

A. Business office functions;

B. Travel expenses other than travel expenses reported under dietary services and those under nursing services.

C. All motor vehicle operating expenses;

D. Telephone and telegraph charges;

E. Office supplies;

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

G. Personnel recruitment costs including help wanted advertising;

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

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

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

K. Central, affiliated, or corporate office costs excluding the cost of depreciable equipment used by individual nursing facilities which are included in the computation of the property-related payment rate and those costs specified in Section 3.040, items A and B;

L. Business meetings and seminars;

M. Postage;

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

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

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

Q. Security services or security personnel;

R. Joint commission on accreditation of hospitals survey;

S. Advertising;

T. Board of director's fees;

U. Interest on working capital debt;

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

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

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

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

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

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

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

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

SECTION 6.080 **Payroll taxes, fringe benefits, and clerical training.** Only the costs identified in items A to I are to be reported in the payroll taxes, fringe benefits, and clerical training cost category;

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

B. State and federal unemployment compensation taxes or costs;

C. Group life insurance;

D. Group health and dental insurance;

E. Workers' compensation insurance including self-insured plans specified in Section 6.083;

F. Either a pension plan or profit-sharing plan, approved by the United States Internal Revenue Service including IRS Section 403 (b) and 408 (k), but not both for the same employee;

G. Governmental required retirement contributions;

H. Uniform allowance; and

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

SECTION 6.083 **Workers compensation self-insurance.** The Department shall allow as workers' compensation insurance costs the costs of workers' compensation coverage obtained under the following conditions:

A. A plan approved by the Commissioner of commerce as a Minnesota group or individual self-insurance plan.

B. A plan in which:

(1) The nursing facility, directly or indirectly, purchases workers' compensation coverage from an authorized insurance carrier;

(2) A related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(3) All of the conditions in item D are met;

C. A plan in which:

(1) the nursing facility, directly or indirectly, purchases workers' compensation coverage from an authorized insurance carrier;

(2) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(3) all of the conditions in item D are met ;

D. Additional conditions are:

(1) the costs of the plan are allowable under the federal Medicare program;

(2) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(3) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(4) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(5) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;

(6) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the

facilities payment rate; and

(7) for the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are paid under this section or Section 22.000. The method of cost allocation is based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operated cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternative method of allocation of self-insurance costs must have been received by the Department no later than May 1, 1998, to take effect on July 1, 1998, or such costs will continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it remains in effect until such time as the group no longer self-insures these costs.

E. Any costs allowed pursuant to items A to C are subject to the following requirements:

(1) If the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the State within 30 days following the date on which excess plan reserves are determined.

(2) Any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation costs in the reporting period in which a distribution or withdrawal is received.

(3) If reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare Program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the Commissioner within 30 days of receipt by the nursing facility or any related organization. The Department shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The Department's authority to implement the audit findings is independent of its authority to conduct a field audit.

F. The Department shall have authority to adopt emergency rules to implement this Section.

SECTION 6.084. **Group health, dental, or life insurance.** For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers pursuant to Section 6.083, item D, subitem (7). The method of cost allocation is the

same as in Section 6.083, item D, subitem (7). The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the Department no later than May 1, 1998, to take effect on July 1, 1998, or such costs will continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it remains in effect until such time as the group no longer self-insures these costs.

SECTION 6.090 **Real estate taxes and special assessments.** Real estate taxes and special assessments for each nursing facility are to be reported in the real estate taxes and special assessments cost category. In addition, payments made in lieu of real estate taxes, unless such payments were made under a legally enforceable irrevocable written contract entered into prior to August 31, 1983, must be reported in this cost category.

SECTION 7.000 ESTABLISHMENT OF GEOGRAPHIC GROUPS

SECTION 7.010 **Classification process.** The Commissioner shall classify Minnesota nursing facilities according to their geographic location.

SECTION 7.020 **Group 1.** All nursing facilities in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

SECTION 7.030 **Group 2.** All nursing facilities in counties other than the counties listed in group 1 and group 3 must be placed in geographic group 2.

SECTION 7.040 **Group 3.** All nursing facilities in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

SECTION 7.050 **Exceptions.**

A. Facilities in geographic Group 1 (lowest cost) may have their rates calculated based on the highest of the limits within Group 2 (middle cost) or Group 1. This exception is granted if it is to the facility's benefit and is done automatically at the time of ratesetting. In the event an exception is granted, efficiency payments are based on Group 1 limits.

B. Effective July 1, 2006, nursing facilities in Benton, Sherburne, and Stearns counties shall

receive an operating rate increase to the median rate of Group 3 facilities.

SECTION 8.000 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETICIAN CONSULTING FEES

SECTION 8.010 **Fringe benefits and payroll taxes until July 1, 2001.** Fringe benefits and payroll taxes must be allocated to case mix, other care-related costs, and other operating costs according to items A to E.

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

B. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under the nursing service category.

C. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under the other care-related services category.

D. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under dietary, laundry and linen, housekeeping, plant operation and maintenance services, and the general and administrative categories.

E. For any nursing facility that cannot separately report each salary component of an operating cost category, the Department shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to the following:(1) The Department shall sum the allowable salaries for all nursing facilities separately reporting allowable salaries in each cost category, by cost category and in total.

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

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

(4) If a nursing facility's salary for any nursing, dietary, laundry, housekeeping, plant operation and maintenance, other care-related services and general and administrative operating cost categories, is zero and the services provided to the nursing facility in that operating cost category are not performed by a related organization, the nursing facility must reclassify one dollar to a salary cost

line in the operating cost category. For rate years beginning on or after July 1, 1989, the Department shall include a nursing facility's reported public employee retirement act contribution for the reporting year as apportioned to the care-related operating cost categories multiplied by the appropriate composite index.

SECTION 8.020 **Determination of food costs until July 1, 1999.** The Department shall determine the costs of food to be included in other care-related costs according to items A and B.

A. For any nursing facility separately reporting food costs, food costs shall be the allowable food costs as reported under the dietary services cost category.

B. For any nursing facility that cannot separately report the cost of food under the dietary services cost category, the Department shall determine the average ratio of food costs to total dietary costs for all nursing facilities that separately reported food costs. The nursing facility's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing facility.

For rate years beginning on or after July 1, 1987 the Department shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.

SECTION 8.030 **Determination of dietician consulting fees until July 1, 1999.** The Department shall determine the dietician consulting fees to be included in other care-related costs according to items A and B.

A. For any nursing facility separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under the dietary services cost category.

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

SECTION 9.000 DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COST PER DIEMS

SECTION 9.010 **Review and adjustment of costs.** The Department shall annually review and adjust the operating costs reported by the nursing facility during the reporting year preceding the rate

year to determine the nursing facility's actual allowable historical operating costs.

SECTION 9.020 **Standardized resident days.** Each nursing facility's standardized resident days must be determined in accordance with items A to B.

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

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

SECTION 9.030 **Allowable historical case mix operating cost standardized per diem.** Until July 1, 1999, the allowable historical case mix operating cost standardized per diem must be computed by the standardized resident days determined in Section 9.020.

SECTION 9.040 **Allowable historical other care-related operating cost per diem.** Until July 1, 1999, the allowable historical other care-related operating cost per diem must be computed by dividing the allowable historical other care-related operating costs by the number of resident days in the nursing facility's reporting year.

SECTION 9.050 **Allowable historical other operating cost per diem.** Until July 1, 1999, the allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the number of resident days in the nursing facility's reporting year.

SECTION 10.000 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS

SECTION 10.010 **Annual adjustment factors through June 30, 1999.** The annual adjustment factors will be determined according to items A and C.

A. The forecasted consumer price index for a nursing facility's allowable operating cost per diems shall be determined using Data Resources, Inc. forecast for the change in the nursing facility market basket between the mid point of the reporting year and the mid point of the rate year. For these purposes, the indices as forecasted by Data Resources, Inc. in the fourth quarter of the calendar year preceding the rate year will be utilized.

B. For rate years beginning on or after July 1, 1994, the Department will index the prior year's operating cost limits by the percentage change in the Data Resources, Inc., nursing home market basket between the midpoint of the current reporting year and the midpoint of the previous reporting year. The Department will use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

C. For the nine month rate period beginning October 1, 1992, the 21-month inflation factor for operating costs in item B shall be increased by an annualization of seven-tenths of one percent rounded to the nearest tenth percent.

SECTION 10.020 **Base year limits.** Until July 1, 1999, for each geographic group the base year operating costs limits must be determined according to items A and B. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement. For purposes of this section, a new base year is established for the rate year beginning July 1, 1992, and July 1, 1993.

A. The adjusted care-related limits must be indexed as in Sections 11.010 and 11.020. The adjusted other operating cost limits must be indexed as in Sections 11.030 and 11.040.

B. The Department shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds the percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative as in subitems (1) to (3). For the purpose of computing the amount of disallowed general and administrative cost, the nursing facility's professional liability and property insurance must be excluded from the general and administrative cost category. For purposes of this item, the term property insurance means general liability coverage for personal injury incurred on the nursing facility property and coverage against loss or damage to the building, building contents, and the property of others on the premises of the nursing facility. Property insurance does not include any coverage for items such as automobiles, loss of earnings, and extra expenses.

(1) If the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent.

(2) If the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) If the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

SECTION 10.030 **Indexed limits.** Until July 1, 1999, the total care related operating cost limit and the other operating cost limit must be determined under items A and B.

A. The annual adjustment factor for case mix and other care related operating costs for the current reporting year as determined in Section 10.010 must be divided by the corresponding annual adjustment factor for the previous reporting year.

B. The annual adjustment factor for other operating costs for the current reporting year as

determined in Section 10.010 must be divided by the corresponding annual adjustment factor for the previous reporting year.

SECTION 11.000 DETERMINATION OF OPERATING COST PAYMENT RATE

SECTION 11.010 **Nonadjusted case mix and other care-related payment rate.** Until July 1, 1999, for each nursing facility, the nonadjusted case mix and other care-related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem must be multiplied by the weight for each resident class.

B. The allowable historical other care-related operating cost per diem must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group item C, the nursing facility's nonadjusted case mix and other care-related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group, the nursing facility's nonadjusted case mix and other care-related payment rate must be set at the limit.

SECTION 11.020 **Adjusted prospective case mix and other care-related payment rate.** Until July 1, 1999, for each nursing facility, the adjusted prospective case mix and other care-related payment rate for each resident class must be the nonadjusted case mix and other care-related payment rate multiplied by the case mix and other care-related adjustment factor.

SECTION 11.030 **Nonadjusted other operating cost payment rate.** Until July 1, 1999, the nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem is below the limit for that group the nursing facility's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem is at or above the limit for that group the nursing facility's nonadjusted other operating cost payment rate must be set at that limit.

SECTION 11.040 **Adjusted prospective other operating cost payment rate until July 1, 1999.** The adjusted prospective other operating cost payment rate must be determined according to items A to C.

A. Except as provided in item B, if the nursing facility's nonadjusted other operating cost payment rate is below the limit for that group, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in Section 11.030, item A, multiplied by the other operating cost adjustment factor plus, for the rate years before July 1, 1999, an efficiency incentive equal to the difference between the other operating cost limits in each geographic group and the nonadjusted other operating cost payment rate in Section 11.030, up to the maximum set forth in Section 11.047, item C.

B. For any short length of stay facility and any nursing facility licensed on June 1, 1983 by the Department to provide residential services for the physically handicapped that is under the limits, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in Section 11.030, item A, multiplied by the other operating cost adjustment factor determined in Section 10.010, item B, plus, for the rate years before July 1, 1999, an efficiency incentive equal to the difference between the other operating cost limits for hospital attached nursing facilities in each geographic group, and the nonadjusted other operating cost payment rate in Section 11.030, up to the maximum set forth in Section 11.047, item C.

C. If the nursing facility's nonadjusted other operating cost payment rate is at or above the limit for that group, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in Section 11.030, item B, multiplied by the other operating cost adjustment factor determined in Section 10.010, item B.

SECTION 11.042 **Efficiency incentive reductions for substandard care.** For rate years beginning on or after July 1, 1991, the efficiency incentive established in Section 11.047, item C, shall be reduced or eliminated for nursing facilities determined by the Commissioner of health to have uncorrected or repeated violations which create a risk to resident care, safety, or rights, except for uncorrected or repeated violations relating to a facility's physical plant. Upon being notified by the Commissioner of health of uncorrected or repeated violations, the Commissioner of human services shall require the nursing facility to use efficiency incentive payments to correct the violations. The Commissioner of human services shall require the nursing facility to forfeit efficiency incentive payments for failure to correct the violations. Any forfeiture shall be limited to the amount necessary to correct the violation.

SECTION 11.046 **Changes to nursing facility reimbursement beginning July 1, 1996.** The nursing facility reimbursement changes in items A through G are effective for one rate year beginning July 1, 1996. In addition, the Department must determine nursing facility payment rates for this rate year without regard to the changes in this section, the results of which will serve as the basis for allowed costs in the following rate years.

A. Except for purposes of the computation of the efficiency incentive in approved State

plan amendment TN 99-10, Section 11.045, item D, which described the methodology for computing a nursing facility's efficiency incentive for rates on or after July 1, 1995, the operating cost limits in Section 10.020, items A and B, and Section 16.138 do not apply.

B. Notwithstanding approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), which specified that the Nursing Home Market Basket forecasted index for allowable operating costs and per diems was based on the 12-month period between the midpoints of the two reporting years preceding the July 1, 1995 rate year, the operating cost limits in Section 10.020, items A and B are indexed for inflation as in Section 10.010, item B.

C. The high cost nursing facility limit in approved State plan amendment TN 99-10, Section 11.045, item B, which described how the high cost limit was determined for the July 1, 1995 rate year, does not apply.

D. The spend-up limit in approved State plan amendment TN 99-10, Section 11.045, item A, subitem (2), which described the allowable operating cost per diem limit, is modified as in subitems (1) to (3).

(1) For those nursing facilities in each grouping whose case mix A operating cost per diem is at or above the median plus 1.0 standard deviation of the array, the nursing facility's allowable operating cost per diem for each case mix category is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), which specified that the Nursing home Market Basket forecasted index for allowable operating costs and per diems was based on the 12-month period between the midpoints of the two reporting years preceding the July 1, 1995 rate year, or the current reporting year's corresponding allowable operating cost per diem.

(2) For those nursing facilities in each grouping whose case mix A operating cost per diem is between .5 and 1.0 standard deviation above the median of the array, the nursing facility's allowable operating cost per diem for each case mix category is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), described in subitem (1), above, increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

(3) For those nursing facilities in each grouping whose case mix A operating cost per diem is equal to or below .5 standard deviation above the median of the array, the nursing facility's allowable operating cost per diem is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), described in subitem (1), above, increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem.

E. A nursing facility licensed by the State to provide services for the physically handicapped shall be exempt from the care related portion of the limit in approved State plan amendment TN 99-10, Section 11.045, item A, subitem (2), which described the allowable operating cost per diem limit.

F. Any reductions to the combined operating cost per diem shall be divided proportionally between the care-related and other operating cost per diems.

G. Each nursing facility's payment rate, except those nursing facilities whose payment rates are established under Section 22.000, are increased by $.06 per resident per day.

SECTION 11.047 **Changes to nursing facility reimbursement beginning July 1, 1997.** The nursing facility reimbursement changes in items A through L shall apply, in the sequence specified, beginning July 1, 1997.

A. For rate years beginning on July 1, 1997 or July 1, 1998, the nursing facility's allowable operating per diem for each case mix category for each rate year shall be limited as described below.

For rate years beginning on July 1, 1997 or July 1, 1998, nursing facilities shall be divided into two groups, freestanding and nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the limits contained in Sections 20.025, 20.030, or 20.035. All other nursing facilities shall be considered freestanding nursing facilities. All nursing facilities in each grouping will be arrayed by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in Section 8.020, item B, shall be excluded.

For those nursing facilities in each grouping whose case mix A operating cost per diem:

(a) is at or below the median of the array, the nursing facility's allowable operating cost per diem for each case mix category shall be limited to the lesser of the prior reporting year's allowable operating cost per diem by computing nursing facility payment rates based on the payment rate methodology in effect on March 1, 1996 (see approved State plan amendment TN 99-10, Section 11.045), plus the inflation factor as established in item D, subitem (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(b) is above the median of the array, the nursing facility's allowable operating cost per diem for each case mix category shall be limited to the lesser of the prior reporting year's allowable operating cost per diems by computing nursing facility payment rates based on the payment rate methodology in effect on March 1, 1996 (see approved State plan amendment TN 99-

10, Section 11.045) plus the inflation factor as established in item D, subitem (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

(c) For the purposes of this item, if a nursing facility reports on its cost report a reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the Department will increase that facility's spend-up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

B. For rate years beginning on July 1, 1997 or July 1, 1998, the allowable operating cost per diems for high cost nursing facilities shall be limited as described. After application of the limits in item A to each nursing facility's operating cost per diems, nursing facilities shall be divided into two groups, freestanding or nonfreestanding, and arrayed within these groupings according to allowable case mix A operating cost per diems.

In calculating a nursing facility's operating cost per diem for this purpose, the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in Section 8.020, item B, shall be excluded.

For those nursing facilities in each grouping whose case mix A operating cost per diems exceeds 1.0 standard deviation above the median, the allowable operating cost per diems will be reduced by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard above the median, the allowable operating cost per diems will be reduced by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

C. For rate years beginning on July 1, 1997 or July 1, 1998, a nursing facility's efficiency incentive shall be determined by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. Then, the efficiency incentive is computed by:

(1) Subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) Multiplying 0.20 by the ratio resulting from subitem (1);

(3) Adding 0.50 to the result from subitem (2); and

(4) Multiplying the result from subitem (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product

obtained through calculations of subitems (1) through (4).

D. For rate years beginning on July 1, 1997 or July 1, 1998, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under subitems (1) and (2) using the change in the Consumer Price Index - All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc. The indices as forecasted in the fourth quarter of the calendar year preceding the rate year shall be used.

(1)The CPI-U forecasted index for allowable operating cost per diems shall be based on the 21-month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) For rate years beginning on July 1, 1997 or July 1, 1998, the forecasted index for operating cost limits referred to in Section 10.010, item B, shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.

E. After applying these provisions for the respective rate years, allowable operating cost per diems shall be indexed by the inflation factor provided for in item D, subitem (1), and the nursing facility's efficiency incentive as calculated in item C shall be added.

F. For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from Section 11.046, items A to D, and Section 11.047, items A to D, respectively.

G. For the rate year beginning July 1, 1997, for a nursing facility that submitted a proposal after January 13, 1994, involving replacement of 102 licensed and certified beds and relocation of the existing first facility to a new location, that was approved under the State's moratorium exception process, the operating cost payment rates for the new location shall be determined pursuant to Section 12.000. The relocation approved under the State's moratorium exception process, and the rate determination allowed under this item must meet the cost neutrality requirements of the State's moratorium exception process. Items A and B do not apply until the second rate year after the settle-up cost report is filed. Notwithstanding Section 17.000, payments in lieu of real estate taxes and special assessments payable by the new location, a non profit corporation, as part of tax increment financing, shall be included in the payment rates determined under this section for all subsequent rate years.

H. For the rate year beginning July 1, 1997, for a nursing facility licensed for 94 beds on September 30, 1996 that applied in October 1993 for approval of a total replacement under the State's moratorium exception process and completed the approved replacement in June 1995, the

Department shall compute the payment rate with other operating cost spend-up limit under item A. This amount is increased by $3.98, and, after computing the facility's payment rate according to this Section, the Department shall make a one-year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of items A and B. The facility's per diem, before the $3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this item is exempt from item B for the rate years beginning July 1, 1997 and July 1, 1998.

I. For the purpose of applying the limit in item A, a nursing facility in Kandiyohi County licensed for 86 beds that was granted hospital-attached status on December 1, 1994, shall have the prior year's allowable care-related per diem increased by $3.207 and the prior year's other operating cost per diem increased by $4.777 before adding the inflation in item D, subitem (2), for the rate year beginning on July 1, 1997.

J. For the purpose of applying the limit stated in item A, a 117 bed nursing facility located in Pine County shall have the prior year's allowable other operating cost per diem increased by $1.50 before adding the inflation in item D, subitem (2), for the rate year beginning on July 1, 1997.

K. For the purpose of applying the limit under item A, a nursing facility located in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost per diem increased by $2.67 before adding the inflation in item D, subitem (2), for the rate year beginning on July 1, 1997.

L. A 49 bed nursing facility located in Norman County and a 129 bed nursing facility located in Polk County destroyed by the spring floods of 1997 are eligible for total replacement. These nursing facilities shall have their operating cost payment rates established using the provisions in Section 12.000, and this State plan amendment, except that the limits in items A and B of this section shall not apply until after the second rate year after the settle-up cost report is filed. The property-related payment rates are determined pursuant to Section 16.000, taking into account any federal or state flood-related loans or grants.

M. (1) After computing the payment rate of the 302 bed nursing facility in Section 11.046, item H, the Department must make a one-year rate adjustment of $8.62 to the facility's contract payment rate for the rate effect of operating cost changes associated with the facility's 1994 downsizing project.

(2) The Department must also add 35 cents to the facility's base property related payment rate for the rate effect of reducing its licensed capacity to 290 beds from 302 beds and must add 83 cents to the facility's real estate tax and special assessment payment rate for payments in lieu of real estate taxes. The adjustments in this subitem must remain in effect for the duration of the facility's contract.

SECTION 11.048 **Changes to nursing facility reimbursement beginning July 1, 1998.**

A. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Hennepin county licensed for 181 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $1.455 and the prior year's other operating cost per diem increased by $0.439 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

B. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Hennepin county licensed for 161 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $1.154 and the prior year's other operating cost per diem increased by $0.256 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

C. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Ramsey county licensed for 176 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $.083 and the prior year's other operating cost per diem increased by $0.272 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

D. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Brown county licensed for 86 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $0.850 and the prior year's other operating cost per diem increased by $0.275 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

E. For the rate year beginning July 1, 1998, the Department will compute the payment rate for a nursing facility, which was licensed for 110 beds on May 1, 1997, was granted approval in January 1994 for a replacement and remodeling project under the moratorium exception process and completed the approval replacement and remodeling project on May 14, 1997, by increasing the other operating cost spend-up limit under item A by $1.64. After computing the facility's payment rate for the rate year beginning July 1, 1998, according to this section, the Department will make a one-year positive rate adjustment of $.48 for increased real estate taxes resulting from completion of the moratorium exception project, without application of items A and B.

F. For the rate year beginning July 1, 1998, the Department will compute the payment rate for a nursing facility exempted from the care-related limits under Section 20.030, with a minimum of three-quarters of its beds licensed to provide residential services for the physically handicapped, with the care-related spend-up limit of Section 11.047, item A, increased by $13.21 for the rate year beginning July 1, 1998, without application of Section 11.047, item B. For rate years beginning on

or after July 1, 999, the Department will exclude that amount in calculating the facility's operating cost per diem for purposes of applying Section 11.047, item B.

G. For the rate year beginning July 1, 1998, a nursing facility in Canby, Minnesota, licensed for 75 beds will be reimbursed without the limitation imposed in Section 11.047, item A, and for rate years beginning on or after July 1, 1999, its base costs will be calculated on the basis of its September 30, 1997 cost report.

H. Effective July 1, 1998, the nursing facility reimbursement changes in subitems (1) and (2) will apply in the sequence specified in this section.

(1) For rate years beginning on July 1, 1998, the operating cost limits established by Section 10.020, item B, subitems (1) through (3); Section 16.138; and any previously effective corresponding limits in state law or rule do not apply, except that these cost limits will still be calculated for purposes of determining efficiency incentive per diems in Section 11.047, item D. For rate years beginning on July 1, 1998, the total operating cost payment rates for a nursing facility are the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1998, subject to rate adjustments due to field audit or rate appeal resolution.

(2) For rate years beginning on July 1, 1998, the operating cost per diem in Section 11.047, item A, subitem (1), units (a) and (b), is the sum of the care-related and other operating per diems for a given case mix class. Any reductions to the combined operating per diem are divided proportionally between the care-related and other operating cost per diems.

I. For rate years beginning on July 1, 1998, the Department will modify the determination of the spend-up limits in Section 11.047, item A, by indexing each group's previous year's median value by the factor in Section 11.0147, item D, subitem (2), plus one percentage point.

J. For rate years beginning on July 1, 1998, the Department will modify the determination of the high cost limits in Section 11.047, item B, by indexing each groups previous year's high cost per diem limits at .5 and one standard deviations above the median by the factor in Section 11.047, item D, subitem (2), plus one percentage point.

SECTION 11.049 **Changes to nursing facility reimbursement beginning July 1, 1999.**

A. The base operating rate is the rate for the rate year beginning July 1, 1998.

B. For the rate year beginning July 1, 1999, the Department will make an adjustment to the total operating payment rate for a nursing facility paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or by the contractual rate-setting methodology described in

Section 22.000 that submits a plan, approved by the Department, in accordance with subitem (2). Total operating costs will be separated into compensation-related costs and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(1) For the rate year beginning July 1, 1999, the payment rate is increased by 4.843 percent of compensation-related costs and 3.446 percent of all other operating costs. A nursing facility's final 1998 Medicare cost report will be used to calculate the adjustment.

(2) To receive the total operating payment rate adjustment, a nursing facility must apply to the Department. The application must contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a nursing facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan.

(a) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in subitem (1).

(b) To be eligible, a nursing facility must submit its plan for the compensation distribution by December 31 each year. A nursing facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a nursing facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(3) The payment rate adjustment for each nursing facility will be determined under clauses (a) or (b).

(a) For a nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility paid under Section 22.000, the Department must determine the proportions of the nursing facility's rates that are compensation-related costs and all other operating costs based on its most recent cost report; or

(b) For a nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment will be computed using the nursing facility's total operating costs, separated into the categories listed above in proportion to the weighted average of all nursing facilities determined under subitem (3), clause (a), multiplied by the rate increases in subitem (1), and then dividing the resulting amount by

the nursing facility's actual resident days.

C. The salary adjustment per diem in Section 11.070 became part of the operating payment rate in effect on June 30, 2001.

D. For the rate year beginning July 1, 1999, the following nursing facilities are allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, item A was not applied:

(1) A nursing facility in Carver county licensed for 33 beds and four boarding care beds;

(2) A nursing facility in Faribault county licensed for 159 beds on September 30, 1998; and

(3) A nursing facility in Houston county licensed for 68 beds on September 30, 1998.

These increases are included in each facility's total payment rates for the purpose of determining future rates.

E. For the rate year beginning July 1, 1999, the following nursing facilities will be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, items A and B were not applied:

(1) A nursing facility in Chisago county licensed for 135 beds on September 30, 1998; and

(2) A nursing facility in Murray county licensed for 62 beds on September 30, 1998.

These increases are included in each facility's total payment rates for the purpose of determining future rates.

F. For the rate year beginning July 1, 1999, a nursing facility in Hennepin county licensed for 134 beds on September 30, 1998, will:

(1) Have the prior year's allowable care-related per diem increased by $3.93 and the prior year's other operating cost per diem increased by $1.69 before adding the inflation in Section 11.047, item D, subitem (2); and

(2) Be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, items A and B were not applied.

These increases are included in the facility's total payment rate for the purpose of determining future rates.

SECTION 11.050 **Changes to nursing facility reimbursement beginning July 1, 2000.**

A. The base operating rate is the rate for the rate year beginning July 1, 1998.

B. For the rate year beginning July 1, 2000, the Department will make an adjustment to the total operating payment rate for a nursing facility paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or by the contractual rate-setting methodology described in Section 22.000 that submits a plan, approved by the Department, in accordance with subitem (2). The operating payment rate increases are applied to each nursing facility's June 30, 2000, operating payment rate.

Total operating costs will be separated into compensation-related costs and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(1) For the rate year beginning July 1, 2000, the payment rate is increased by:

(a) 3.632 percent of compensation-related costs;

(b) an additional increase for each case mix payment rate that must be used to increase the per-hour pay rate of all employees except management fees, the administrator, and central office staff by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance, to be calculated according to the following:

1. the Department calculates the arithmetic mean of the eleven June 30, 2000, operating rates for each nursing facility;

2. the Department constructs an array of nursing facilities from highest to lowest, according to the arithmetic mean calculated in clause 1. A numerical rank is assigned to each facility in the array. The facility with the highest mean is assigned a numerical rank of one. The facility with the lowest mean is assigned a numerical rank equal to the total number of nursing facilities in the array. All other facilities are assigned a numerical rank in accordance with their position in the array;

3. the amount of the additional rate increase is $1.00 plus an amount equal to $3.13 multiplied by the ratio of the facility's numeric rank divided by the number of facilities in the array; and

(c) 2.585 percent of all other operating costs. A nursing facility's final 1999 Medicare cost report will be used to calculate the adjustment.

Money received by a nursing facility as a result of the increase provided by (b), above, must be used only for wage increases implemented on or after July 1, 2000, and must not be used for wage increases implemented before then.

(2) To receive the total operating payment rate adjustment, a nursing facility must apply to the Department. The application must contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a nursing facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, but only if the agreement is finalized after May 16, 2000.

(a) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in subitem (1).

(b) To be eligible, a nursing facility must submit its plan for the compensation distribution by December 31 each year. A nursing facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a nursing facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(3) The payment rate adjustment for each nursing facility will be determined under clauses (a) or (b).

(a) For a nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility paid under Section 22.000, the Department must determine the proportions of the nursing facility's rates that are compensation-related costs and all other operating costs based on its most recent cost report; or

(b) For a nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment will be computed using the nursing facility's total operating costs, separated into the categories listed above in proportion to the weighted average of all nursing facilities determined under subitem (3), clause (a), multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days.

C. The salary adjustment per diem in Section 11.070 became part of the operating payment rate in effect on June 30, 2001.

D. For rate years beginning on or after July 1, 2000, a nursing facility in Goodhue county that was licensed for 104 beds on February 1, 2000, shall have its employee pension benefit costs reported on its Rule 50 cost report treated as PERA contributions for the purpose of computing its payment rates.

E. Following the determination under item B, a facility in Roseau county licensed for 49 beds, has its operating cost per diem increased by the following amounts:

(1) case mix class A, $1.97;

(2) case mix class B, $2.11;

(3) case mix class C, $2.26;

(4) case mix class D, $2.39;

(5 case mix class E, $2.54;

(6) case mix class F, $2.55;

(7) case mix class G, $2.66;

(8) case mix class H, $2.90;

(9) case mix class I, $2.97;

(10) case mix class J, $3.10; and

(11) case mix class K, $3.36.

These increases are included in the facility's total payment rates for the purpose of determining future rates.

SECTION 11.051 **Changes to nursing facility reimbursement beginning July 1, 2001.**

A. For the rate year beginning July 1, 2001, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on

June 30, 2001 include the adjustment in Section 11.070.

B. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, the total payment rate for the first 90 paid days after admission is:

(1) for the first 30 paid days, 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, 110 percent of the facility's medical assistance rate for each case mix class.

C. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, beginning with the 91st paid day after admission, the payment rate is the rate otherwise determined under this Attachment.

D. Payments under item B apply to admissions occurring on or after July 1, 2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.

E. For the rate year beginning July 1, 2001, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2001, below, the Department will make available the lesser of the amount of the operating payment rate target level for July 1, 2001, or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Brekenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids.

Operating Payment Rate Target Level for July 1, 2001

Case Mix Classification	Metro	Nonmetro
A	$76.00	$68.13
B	$83.40	$74.46
C	$91.67	$81.63
D	$99.51	$88.04
E	$107.46	$94.87
F	$107.96	$95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.34	$115.06
J	$138.34	$120.85

K	$152.26	$133.10

E. For the rate year beginning July 1, 2001, two-thirds of the money resulting from the rate adjustment under item A, and one-half of the money resulting from the rate adjustment under items B through D, must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under items A through D must be used only for wage and benefit increases implemented on or after July 1, 2001.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, if the agreement is finalized after June 30, 2001.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2001. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2001, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2001. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

F. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under items A through D. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this

purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

G. For rate years beginning on or after July 1, 2001, in calculating a facility's operating cost per diem for the purposes of constructing an array, determining a median, or otherwise performing a statistical measure of facility payment rates to be used to determine future rate increases, the Department will exclude adjustments for raw food costs under Section 8.020, item B, that are related to providing special diets based on religious beliefs.

SECTION 11.052 **Changes to nursing facility reimbursement beginning July 1, 2002.**

A. For the rate year beginning July 1, 2002, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For the rate year beginning July 1, 2002, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2002, below, the Department will make available the lesser of the operating payment rate target level for July 1, 2002, or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they meet the requirements in Section 11.051, item D.

Operating Payment Rate Target Level for July 1, 2002

Case Mix Classification	Metro	Nonmetro
A	$78.28	$70.51
B	$85.91	$77.16
C	$94.42	$84.62
D	$102.50	$91.42
E	$110.68	$98.40
F	$111.20	$98.84
G	$118.11	$104.77
H	$130.80	$115.64

I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

C. For the rate year beginning July 1, 2002, two-thirds of the money resulting from the rate adjustment under item A, and one-half of the money resulting from the rate adjustment under Section 11.051, items B and C and item B of this Section, must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under item A, Section 11.051, items B and C and item B of this Section must be used only for wage and benefit increases implemented on or after July 1, 2002.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, if the agreement is finalized after the date of enactment of all increases for the rate year.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2002. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2002, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2002. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

D. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by

the amount anticipated to be required upon implementation of the rate adjustments allowable under item A, Section 11.051, items B and C, and item B of this Section. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

E. Each facility paid pursuant to Sections 1.000 through 22.000 receives an increase in each case mix payment rate of $1.25, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase.

SECTION 11.053 **Changes to nursing facility reimbursement beginning June 1, 2003.**

Each facility paid pursuant to Sections 1.000 through 21.000 receives an increase in each case mix payment rate of $5.56, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase. For facilities with board and care beds, the increase is equal to $5.56 multiplied by the ratio of the number of nursing home beds to the number of total beds.

SECTION 11.054 **Changes to nursing facility reimbursement beginning July 1, 2003.**

A. For rate years beginning on or after July 1, 2003 and for admissions occurring on or after July 1, 2003, the total payment rate is:

(1) for the first 30 calendar days after admission, 120 percent of the facility's medical assistance rate for each RUG class; and

(2) beginning with the 31st calendar day after admission, the rate otherwise determined under Sections 1.000 through 21.000.

B. For rate years beginning on or after July 1, 2003, facilities' July 1 operating payment rate is equal to their operating payment rate in effect on the prior June 30.

SECTION 11.055 **Changes to nursing facility reimbursement beginning January 1, 2004.** Effective January 1, 2004, the rates under Section 11.054, item A, subitem (1) are not allowed if a resident has resided during the previous 30 calendar days in:

(1) the same facility;

(2) a facility owned or operated by a related party; or

(3) a facility or part of a facility that closed or, effective August 1, 2004, was in the process of closing.

SECTION 11.056 **Changes to nursing facility reimbursement beginning July 1, 2005.**

A. Medical Assistance provides for an additional annual payment for: 1) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; and 2) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007, to Medical Assistance-enrolled teaching nursing facilities. The Medical Assistance payment is increased according to the sum of items A through C:

(1) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .67, multiplied by [(the number of full-time equivalent trainees at the facility multiplied by the average cost per trainee for all sites) divided by (the total training costs across all sites)], for each type of graduate trainee at the clinical site.

(2) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .33, multiplied by the ratio of the facility's public program revenue to the public program revenue for all teaching sites.

(3) (A portion of the total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund minus $4,850,000), divided by the state matching rate, multiplied by .10, multiplied by the provider's sponsoring institution's ratio of the amounts in subitems (1) and (2) to the total dollars available under subitems (1) and (2), in the amount the sponsoring institution determines is necessary to offset clinical costs at the facility.

In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper limit payment and charge limits as specified in Code of Federal Regulations, title 4, section 447.272.

B. Pursuant to subitems (1) through (3), the operating payment rate for each facility paid pursuant to Sections 1.000 through 21.000 is increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created, divided by the number of active beds on July 1, 2005, for

each bed closure resulting in the creation of a single-bed room after July 1, 2005.

(1) The Department may implement rate adjustments for up to 3,000 new single-bed rooms each fiscal year.

(2) For eligible bed closures for which the Department receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room has been established, the rate adjustment is effective on the first day of the second month following that calendar quarter.

(3) A facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A facility must submit documentation to the Department certifying the occupancy status of beds closed to create single-bed rooms.

SECTION 11.057 **Changes to nursing facility reimbursement beginning October 1, 2005.**

A. For the rate period beginning October 1, 2005, each facility paid pursuant to Sections 1.000 through 21.000 receives an adjustment equal to 2.2553 percent of the total operating payment rate. The adjustment is distributed according to items B through D, below.

B. Except as provided in item C, 75% of the money resulting from the rate adjustment must be used to increase employee wages, benefits and associated costs and must be implemented on or after the effective date of the rate increase. "Employee" does not include management fees, the administrator, and central office staff.

C. A facility that incurred costs for employee wages, benefits and associated cost increases first provided after July 1, 2003 may count those costs toward the amount required to be spent on the items in item B. These costs must be reported to the Department.

D. A facility may apply for the 75% portion of the rate adjustment for employee wages, benefits and associated costs. The application must be made to the Department and contain a plan by which the facility will distribute the funds according to items B through C. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan, if the agreement is finalized after that date of enactment of all increases for the rate period and signed by both parties prior to submission to the Department.

(1) The Department will review the plan to ensure that the rate adjustments are used as required in items B through C.

(2) To be eligible, a facility must submit its distribution plan by March 31, 2006. If a

facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same day as the facility's plan.

(3) The Department must approve or disapprove distribution plans on or before June 30, 2006.

SECTION 11.058 **Changes to nursing facility reimbursement beginning October 1, 2006.**

Effective October 1, 2006, a facility that elects to have its rates determined under sections 1.000 through 21.000 of Attachment 4.19-D will continue to be paid the rate in effect for rate year October 1, 2005 through September 30, 2006.

SECTION 11.060 **Total operating cost payment rate.** Through June 30, 1999, the nursing facility's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care-related payment rate determined in Section 11.020 and the adjusted other operating cost payment rate determined in Section 11.040.

SECTION 11.070 **Salary adjustment per diem.** Effective July 1, 1998, the Department shall make available the appropriate salary adjustment per diem calculated in item A through D to the total operating cost payment rate of each nursing facility subject to payment under this attachment, including Section 22.000. The salary adjustment per diem for each nursing facility must be determined as follows:

A. For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the Department shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

B. For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under item A.

C. A nursing facility may apply for the salary adjustment per diem calculated under items A and B. The application must be made to the Department and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. In order to apply for a salary adjustment, a facility reimbursed pursuant to Section 22.000 must report the information required by items A or B in the application, in the manner specified by the Department. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may

constitute the plan for the salary distribution. The Department will review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem is effective the same date as its plan.

D. Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998 cost report.

SECTION 12.000 DETERMINATION OF INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES

SECTION 12.010 **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in Section 16.140, items A to C. The Department shall determine interim and settle-up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to Sections 12.020 and 12.030.

SECTION 12.020 **Interim operating cost payment rate.** Notwithstanding sections 8.000 through 11.000 that were effective until July 1, 1999 (or Section 8.010 that was effective until July 1, 2001), for the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to Sections 1.000 to 15.000, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in Section 13.000 to determine the anticipated standardized resident days for the reporting period.

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

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

D. The annual adjustment factors determined in Section 10.010, must not be applied to the nursing facility's allowable historical per diems as provided in Sections 11.020 and 11.040.

E. The efficiency incentive in Section 11.040, items A or B, must not apply.

SECTION 12.030 **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

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

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

(1) The standardized resident days as determined in Section 9.020 must be used for the interim period.

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

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

(4) The annual adjustment factors determined in Section 10.010 must not be applied to the nursing facility's allowable historical per diems.

(5) The efficiency incentive in Section 11.040, items A or B, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in Section 11.040, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under Sections 6.000 to 16.090.

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

SECTION 14.000 RESIDENT CLASSES, CLASS WEIGHTS AND RESIDENT ASSESSMENT SCHEDULES.

SECTION 14.010 **Resident classes.** Resident classifications are based on the Minimum Data Set (MDS), version 2.0 assessment instrument, or its successor, mandated by the Centers for Medicare & Medicaid Services. The Department of Health establishes resident classes according to the 34-group, Resource Utilization Group, version III (RUG-III) model. Resident classes are established based on the individual items on the MDS set and must be completed according to the facility manual for case

mix classification issued by the Department of Health.

A. Each resident is classified based on the information from the MDS according to the general domains in subitems (1) to (7):

(1) extensive services when a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation when a resident requires physical, occupational, or speech therapy;

(3) special care when a resident has:

(a) cerebral palsy;

(b) quadriplegia;

(c) multiple sclerosis;

(d) pressure ulcers;

(e) ulcers;

(f) fever with vomiting, weight loss, pneumonia, or dehydration;

(g) surgical wounds with treatment;

(h) tube feeding and aphasia; or

(i) is receiving radiation therapy;

(4) clinically complex status when a resident has tube feeding, burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, dialysis, oxygen, transfusions, foot infections or lesions with treatment, heiplegia/hemiparesis, physician visits or order changes, or diabetes with injections and order changes;

(5) impaired cognition when a resident has poor cognitive performance;

(6) behavior problems when a resident exhibits wandering or socially inappropriate or disruptive behavior, has hallucinations or delusions, is physically or verbally abusive toward others, or resists care, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning when a resident has no special clinical conditions.

B. Detailed descriptions of each RUG are defined in the facility manual for case mix classification issued by the Department of Health. The 34 groups are:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;

(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;

(7) RAA: requires rehabilitation services and ADL count is four to nine;

(8) SSC: requires special care and ADL count is 17 or 18;

(9) SSB: requires special care and ADL count is 15 or 16;

(10) SSA: requires special care and ADL count is seven to 14;

(11) CC2: clinically complex with depression and ADL count is 17 or 18;

(12) CC1: clinically complex with no depression and ADL count is 17 or 18;

(13) CB2: clinically complex with depression and ADL count is 12 to 16;

(14) CB1: clinically complex with no depression and ADL count is 12 to 16;

(15) CA2: clinically complex with depression and ADL count is four to 11;

(16) CA1: clinically complex with no depression and ADL count is four to 11;

(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;