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)

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

JUN - 8 2012

RE: Minnesota State Plan Amendment (SPA) 12-11

Dear Mr. Godfrey:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-11. Effective for services on or after January 1, 2012, this amendment revises methods and standards for determining payment rates for services provided by nursing facilities (NF). Specifically, with this amendment the State will use the minimum data set (MDS) version 3.0 assessment instrument and transition its case mix system to the 48 group resource utilization group (RUG)-IV model when determining case mix classifications for NF residents for rate setting purposes. Additionally, this amendment proposes to add penalty and default groups for a total of 50 RUG levels.

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 12-11 is approved effective January 1, 2012. 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,

[redacted]

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: 12-11

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
January 1, 2012

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:
b. FFY '13:

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-D (Non-State Government-Owned or Operated NF), pp.1-~~92~~ 192

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-D, pp. 1-~~188~~ 185

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. SIGN[redacted]TE AGENCY OFFICIAL:

13. TYPE[redacted]
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
March 13, 2012

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:
JUN - 8 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 1 2012

20. SIGNAT[redacted]CIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:
Pen & ink change made to boxes 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)

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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** A. Effective January 1, 2012, r~~R~~esident classifications are based on the Minimum Data Set (MDS), version ~~2.0~~ 3.0 assessment instrument, or its successor, mandated by the Centers for Medicare & Medicaid Services. The Department of Health establishes resident classes according to the ~~34~~ 48-group, Resource Utilization Group, version ~~III~~ IV (RUG-~~III~~ IV) model. In addition to the 48-group RUG-IV classes, there are penalty and default classes. 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.~~B. Each resident must be ~~is~~ classified based on the information from the MDS according to ~~the~~ general domains ~~in subitems (1) to (7)~~ as defined in the facility manual for case mix classification issued by the Department of Health.

~~(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;~~

~~(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;~~

~~(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;~~

~~(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;~~

~~(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;~~

~~(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;~~

~~(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;~~

~~(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;~~

~~(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;~~

~~(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;~~

~~(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is~~

~~11 to 15;~~

~~(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;~~

~~(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;~~

~~(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;~~

~~(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;~~

~~(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;~~

~~(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and~~

~~(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.~~

SECTION 14.020 **Class weights.** The Department assigns a case mix index to each resident class based on the Centers for Medicare & Medicaid Services' staff time measurement study~~, adjusted for Minnesota specific wage indices~~. An index maximization approach is used to classify residents. Residents are classified into the class for which they qualify that has the highest case mix value.

A. The Department assigns case mix indices to each resident class according to subitems (1) to ~~(34)~~ (50).

~~(1) Class SE3, 2.02;~~

~~(2) Class SE2, 1.71;~~

~~(3) Class SE1, 1.51;~~

~~(4) Class RAD, 1.62;~~

~~(5) Class RAC, 1.28;~~

~~(6) Class RAB, 1.20;~~

~~(7) Class RAA, 1.04;~~
~~(8) Class SSC, 1.40;~~

~~(9) Class SSB, 1.32;~~

~~(10) Class SSA, 1.23;~~

~~(11) Class CC2, 1.49;~~

~~(12) Class CC1, 1.25;~~

~~(13) Class CB2, 1.14;~~

~~(14) Class CB1, 1.04;~~

~~(15) Class CA2, 1.04;~~

~~(16) Class CA1, 0.92;~~

~~(17) Class IB2, 0.85;~~

~~(18) Class IB1, 0.74;~~

~~(19) Class IA2, 0.69;~~

~~(20) Class IA1, 0.53;~~

~~(21) Class BB2, 0.73;~~

~~(22) Class BB1, 0.69;~~

~~(23) Class BA2, 0.61;~~

~~(24) Class BA1, 0.59;~~

~~(25) Class PE2, 1.00;~~

~~(26) Class PE1, 0.98;~~

~~(27) Class PD2, 0.85;~~

~~(28) Class PD1, 0.84;~~
~~(29) Class PC2, 0.84;~~

~~(30) Class PC1, 0.84;~~

~~(31) Class PB2, 0.63;~~

~~(32) Class PB1, 0.63;~~

~~(33) Class PA2, 0.60;~~

~~(34) Class PA1, 0.59.~~

(1) Class ES3, 3.00;

(2) Class ES2, 2.23;

(3) Class ES1, 2.22;

(4) Class RAE, 1.65;

(5) Class RAD, 1.58;

(6) Clas RAC, 1.36;

(7) Class RAB, 1.10;

(8) Class RAA, 0.82;

(9) Class HE2, 1.88;

(10) Class HE1, 1.47;

(11) Class HD2, 1.69;

(12) Class HD1, 1.33;

(13) Class HC2, 1.57;

(14) Class HC1, 1.23;

(15) Class HB2, 1.55;

(16) Class HB1, 1.22;

(17) Class LE2, 1.61;

(18) Class LE1,1.26;

(19) Class LD2, 1.54;

(20) Class LD1, 1.21;

(21) Class LC2, 1.30;

(22) Class LC1, 1.02;

(23) Class LB2, 1.21;

(24) Class LB1, 0.95;

(25) Class CE2, 1.39;

(26) Class CE1, 1.25;

(27) Class CD2, 1.29;

(28) Class CD1, 1.15;

(29) Class CC2, 1.08;

(30) Class CC1, 0.96;

(31) Class CB2, 0.95;

(32) Class CB1, 0.85;

(33) Class CA2, 0.73;

(34) Class CA1, 0.65;

(35) Class BB2, 0.81;

(36) Class BB1, 0.75;

(37) Class BA2, 0.58;

(38) Class BA1, 0.53;

(39) Class PE2; 1.25;

(40) Class PE1, 1.17;

(41) Class PD2, 1.15;

(42) Class PD1, 1.06;

(43) Class PC2, 0.91;

(44) Class PC1, 0.85;

(45) Class PB2, 0.70;

(46) Class PB1, 0.65;

(47) Class PA2, 0.49;

(48) Class PA1, 0.45;

(49) Class AAA, 0.45 (penalty);

(50) Class DDF, 1.00 (default).

~~B. After implementation of the RUG-III case mix system, the Department may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing will be calculated in a facility-specific budget neutral manner as described in Section 14.040.~~

SECTION 14.030 **Resident assessment schedule.** Nursing facilities must conduct and electronically submit to the Department of Health case mix assessments that conform to the assessment schedule defined in Code of Federal Regulations, title 42, section 483.20, and published by the Centers for Medicare & Medicaid Services in the Long Term Care Assessment Instrument User's Manual, version ~~2.0 (October 1995)~~3.0, and subsequent ~~clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996~~updates when issued by the Centers for Medicare and Medicaid Services. The Department of Health may substitute successor Centers for Medicare & Medicaid Services' manuals or question and answer documents to replace or supplement the current version of the manual or document.

A. The case mix assessments used for Minnesota's case mix classifications are:

(1) New admission assessments, which must be completed by day 14 following admission;

(2) Annual assessments, which must be completed within 366 days of the last comprehensive assessment;

(3) Significant change assessments, which must be completed within 14 days of the identification of a significant change; and

(4) Quarterly assessments, which must be completed following new admission assessments, annual assessments, and significant change assessments (if significant change assessments have been made). Each quarterly assessment must be completed within 92 days of the

previous assessment.

B. (1) A facility must submit to the Department of Health an initial admission assessment for all residents who stay in the facility less than 14 days.

(2) Notwithstanding subitem (1), in lieu of submitting an initial admission assessment, a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days. Residents with a stay of less than 14 days who are admitted to a nursing facility that makes this election for all stays of less than 14 days will be assigned a RUG case mix classification code of DDF.

(3) Nursing facilities must elect one of the options in subitems (1) and (2) with the Department of Health on an annual basis. The election will be effective on the following July 1.

C. Residents who are admitted and readmitted and leave the facility on a frequent basis and for whom readmission is expected may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in item B.

D. A facility that fails to complete or submit an assessment for a RUG- ~~III~~ IV classification within seven days of the time requirements according to the schedule in item A is subject to a reduced rate for that resident. The resident for whom the facility failed to complete or submit an assessment within the time required will be assigned a RUG case mix classification code ~~BC1~~AAA. The reduced rate is the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

E. Resident reimbursement classifications will be effective:

(1) The day of admission for new admission assessments.

(2) The assessment reference date, which is the last day of the MDS observation period, for significant change assessments.

(3) The first day of the month following the assessment reference date for annual and quarterly assessments.

~~(4) Effective with the rate year beginning October 1, 2006, payment rates will be~~

~~rebased to account for the change to a quarterly assessment schedule in a facility-specific budget neutral manner.~~

SECTION 14.040 **Rate determination upon transition to RUG-~~III~~ -IV payment rates.** ~~The Department determines payment rates at the time of transition to the RUG-III model in a facility-specific, budget-neutral manner in accordance with items A through C.~~

A. Effective January 1, 2012, ~~T~~the Department determines payment rates ~~at the time of transition to the RUG-III~~ using the RUGS-IV based payment model in a facility-specific, budget-neutral manner ~~in accordance with items A through C~~. To transition from the current calculation methodology to the RUG-IV-based methodology nursing facilities reported to the Department the private pay and Medicaid resident days classified under both RUG-III and RUG-IV for the six-month reporting period ending June 30, 2011. This report was submitted to the Department, in a form prescribed by the Department, by August 15, 2011. The Department used this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

~~The case mix indices as defined in Section 14.020, item A are used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG-III model, the Department of Health reports to the Department of Human Services the resident days classified according to the categories defined in Section 14.010, item B for the 12-month reporting period ending September 30, 2001 for each nursing facility. The Department uses this data to compute the standardized days for the reporting period under the RUG-III system.~~

~~B. The Department determines the case mix adjusted component of the rate following the steps in to subitems (1) through (6):~~

~~(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002 plus any rate adjustments that are effective on or after July 1, 2002.~~

~~(2) multiply each amount in subitem (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001.~~

~~(3) compute the sum of the amounts in subitem (2).~~

~~(4) determine the total RUG standardized days for the reporting period ending September 30, 2001.~~

~~(5) divide the amount in subitem (3) by the amount in subitem (4), which is the average case mix adjusted component of the rate under the RUG-III method.~~

~~(6) multiply the result of subitem (5) by the case mix weight in Section 14.020, item A for each RUG group.~~

~~(C) The non-case mix component is allocated to each RUG group as a constant amount to determine the transition payment rate to be effective October 1, 2002.~~

B. The Department determines the case mix adjusted component for the rate for services on or after January 1, 2012, as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under section 14.020, item A.;

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in section 14.020, item A. for each RUG-IV group.

C. The noncase mix components were allocated to each RUG group as a constant amount to determine the operating payment rate.

SECTION 15.000 RESIDENT ASSESSMENT

SECTION 15.010 **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's case mix class.

A. The county long-term care consultation team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening.

B. For an applicant whose admission to the nursing facility is for the purpose of receiving respite care services, preadmission screening is not required more than once every six months.

SECTION 15.020 **Change in resident class due to audits of assessments of nursing facility residents.** Any change in resident class due to a reclassification must be retroactive to the effective date of the assessment audited.

SECTION 15.030 **False information.** If the nursing facility knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the Department shall apply the penalties in Section 2.150.

SECTION 15.040 **Audit authority.** The Department of Health may audit assessments of nursing facility and boarding care home residents.

The audits may be conducted at the facility, and the Department of Health may conduct the audits on an unannounced basis.

SECTION 15.050 **Notice of resident reimbursement classification.** On an annual basis, a nursing facility must elect either item A or item B and notify the Department of Health of the election. If no election is made, item A is the default method to notify residents of their reimbursement classification. The election will be effective the following July 1.

A. The Department of Health generates a notice to inform each resident, and the nursing facility or boarding care home in which the resident resides, of the reimbursement classification

established. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the Commissioner, and the opportunity to request a reconsideration of the classification. The notice must be sent by first-class mail. The notices are sent to the resident's nursing facility. The nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notice.

B. A facility generates a classification notice, as prescribed by the Department of Health, to each resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the Department of Health. The nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the Department of Health. If a facility elects this option, the Department of Health will provide the facility with a list of residents and their case mix classifications as determined by the Department of Health.

C. If a facility submits a correction to an assessment conducted under Section 14.030 that results in a change in case mix classification, the facility must give written notice to the resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident, the person responsible for the payment of the resident's nursing home expenses, or another person designated by the resident is provided the resident's corrected notice of classification.

SECTION 15.060 **Request for reconsideration of classification.** The resident may request that the Commissioner reconsider the assigned reimbursement classification. The request must be submitted in writing within 30 days of the receipt of the notice. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

SECTION 15.070 **Facility's request for reconsideration.** In addition to the information in Section 15.060 a reconsideration request from a nursing facility must contain the following information: the date the notice was received by the facility; the date the notices were distributed to the resident; and a copy of the notice sent to the resident. This notice must tell the resident that a reconsideration of the classification is being requested, the reason for the request, that the resident's rate will change if the request is approved and the extent of the change, that copies of the facility's request and supporting documentation are available for review and that the resident also has the right to request a

reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

SECTION 15.080 **Reconsideration.** The Commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the Department. If necessary for evaluating the reconsideration request, the Department may conduct on-site reviews. In its discretion, the Department may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request, the Department shall affirm or modify the original resident classification. The original classification must be modified if the Department determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing facility shall be notified within five working days after the decision is made. The Department's decision under this subdivision is the final administrative decision of the agency.

SECTION 15.090 **Change in resident class due to a request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

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

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

SECTION 15.100 **Resident access to assessments and documentation.** The nursing facility must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing facility resident or the resident's authorized representative according to items A to D.

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

B. The nursing facility must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the Department 30 days before the increase takes effect. The notice must specify the current

classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

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

D. Upon written request, the nursing facility must give the resident a copy of the assessment form and the other documentation that was given to the Department to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.

SECTION 16.000 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE

The appraised values determined under Sections 16.010 to 16.040 are not adjusted for sales or reorganizations of provider entities.

SECTION 16.010 **Initial appraised value.** For the rate year beginning July 1, 1985, and until August 31, 1992, the Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to determine the appraised value of each nursing facility participating in the medical assistance program as of June 30, 1985. The initial appraised value of each nursing facility and any subsequent reappraisal under Sections 16.020 and 16.030 must be limited to the value of buildings, attached fixtures, and land improvements used by the nursing facility and must be subject to the limits in Section 16.040.

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

For a newly-constructed nursing facility applying to participate in the medical assistance program which commenced construction after June 30, 1985 and until August 31, 1992, or a nursing facility with an increase in licensed beds of 50 percent or more, the Department shall require an initial appraisal upon completion of the construction. The construction is considered complete upon issuance of a certificate of occupancy or, if no certification of occupancy is required, when available for resident use. The property-related payment rate is effective on the earlier of either the first day a resident is admitted or on the date the nursing facility is certified for medical assistance.

SECTION 16.020 **Routine updating of appraised value.** For rate years beginning after June 30, 1986 and until July 1, 1992, the Department shall routinely update the appraised value according to items A to C.

A. The Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to perform reappraisals. Each calendar year, the Department shall select a random sample of not less than 15 percent of the total number of nursing facilities participating in the medical assistance program as of July 1, of that year. The sample must not include nursing facilities receiving an interim payment rate under Section 16.140. All nursing facilities in the sample must be reappraised during the last six months of the calendar year. Incomplete additions or replacements must not be included in the reappraisals. An incomplete addition or replacement is one for which a certificate of occupancy is not yet issued, or if a certificate of occupancy is not required, the addition or replacement is not available for use.

The updated appraised value for hospital-attached nursing facilities resulting from a reappraisal of shared service areas must be allocated to the nursing facility in the same ratio indicated by the Medicare stepdown in effect on September 30 of the rate year in which the reappraisal is conducted. The method described in Section 16.010, is to be used to determine allocation of the updated appraised value. The reappraised value of the shared service areas allocated to the nursing facility must be added to the reappraised value of the nursing facility's buildings, attached fixtures, and land improvements.

B. The Department shall compute the average percentage change in appraised values for the nursing facilities in the sample. The appraised value of each nursing facility not in the sample, and not reappraised under Section 16.030, must be increased or decreased by the average percentage change subject to the limits in Section 16.040. No redetermination of the average percentage change in appraised values shall be made as a result of changes in the appraised value of individual nursing facilities in the sample made after the Department's computation of the average percentage change.

C. For hospital-attached nursing facilities not in the sample, the allocation of the appraised value of the shared service areas must be recomputed if the hospital involved experiences a

cumulative change in total patient days as defined by the Medicare program of more than 15 percent from the reporting year in which the most recently used set of allocation statistics were determined. The allocation using the method described in Section 16.010 must be based on the Medicare stepdown in effect on September 30 of the rate year in which the updating of the appraised value is performed.

D. The adjustment to the property-related payment rate which results from updating the appraised value is effective for the rate year immediately following the rate year in which the updating takes place except as provided in Section 16.140.

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

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

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

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

(4) If the required sample size in subitem (3) is greater than the sample size used in item A, additional appraisals must be performed until the number of appraisals is equal to the required sample size in subitem (3). The additional nursing facilities needed to complete the required sample size must be randomly selected. A nursing facility that is receiving a special reappraisal under Section 16.030, or one that is receiving an interim payment rate under Section 16.140, or one that was appraised in the original sample in item A must be excluded. The average percentage change in appraised values in item B must be recomputed based on the increased sample size in subitem (3).

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

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

SECTION 16.030 **Special reappraisals.** Special reappraisals are subject to the requirements of items A to F.

A. A nursing facility which makes an addition to or replacement of buildings, attached fixtures, or land improvements may request the Department to conduct a reappraisal upon project completion. A special reappraisal request must be submitted to the Department within 60 days after the project's completion date to be considered eligible for a special reappraisal. If a project has multiple completion dates or involves multiple projects, only projects or parts of projects with completion dates within one year of the completion date associated with a special reappraisal request can be included for the purpose of establishing the nursing facility's eligibility for a special reappraisal. A facility which is eligible to request, has requested, or has received a special reappraisal during the calendar year must not be included in the random sample process used to determine the average percentage change in appraised value of nursing facilities in the sample.

Upon receipt of a written request, the Department shall conduct a reappraisal within 60 days provided that all conditions of this section are met. The total historical cost of the addition or replacement, exclusive of the proceeds from disposals of capital assets or applicable credits such as public grants and insurance proceeds, must exceed the lesser of $200,000 or ten percent of the most recent appraised value. The addition or replacement must be complete and a certificate of occupancy issued, or if a certificate of occupancy is not required, the addition or replacement must be available for use. Special reappraisals under this item are limited to one per 12-month period.

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

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

D. The Department shall reappraise every nursing facility at least once every seven calendar years following the initial appraisal. The Department shall reappraise a nursing facility if at the end of seven calendar years the nursing facility has not been reappraised at least once under Sections 16.020 or 16.030. The Department shall postpone the first seventh year catch-up reappraisals until the ninth year after the initial appraisal of all nursing facilities. The Department shall adjust the property-related payment rate to reflect the change in appraised value. The adjustment of the property-related payment rate is effective on the first day of the rate year immediately following the reappraisal.

E. The Department may require the reappraisal of a nursing facility within 60 days of receipt of information provided by the Minnesota Department of Health regarding the violation of standards

and rules relating to the condition of capital assets.

F. Changes in the appraised value computed in this section must not be used to compute the average percentage change in Section 16.020, item B.

SECTION 16.035 **Appraisal sample stabilization.** The percent change in appraised values used for routine updating of appraised values shall be stabilized by eliminating from the sample of nursing facilities those appraisals that represent the five highest and the five lowest deviations from those nursing facilities previously established appraised values.

SECTION 16.040 **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to G.

A. The replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) For the rate year beginning July 1, 1992, the replacement-cost-new per bed limit must be $37,786 per licensed bed in multiple bedrooms and $56,635 per licensed bed in a single bedroom. After September 30, 1992, new projects which meet the requirements in Section 16.1374, item E, shall receive the replacement-cost-new per bed limits in that provision.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in Section 16.100, item A and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1991.

(4) On each succeeding January 1, the Department will adjust the limit in subitem (1) and the depreciable equipment costs in subitem (2) by the percentage change in the composite index published by the Bureau of the Economic Analysis: Price indexes for Private Fixed Investments in Structures; Special Care for the two previous Octobers..

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

(1) The multiple bedroom replacement cost new per bed limit in item A must be

multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in Section 16.110, item C, subitem (2).

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

C. The nursing facility's replacement cost new determined in Sections 16.010 to 16.030 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under Sections 1.000 to 19.050. Examples of such adjustments include non-nursing facility areas, or shared areas, therapy areas, day care areas, etc.

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

E. The adjusted depreciation is determined by subtracting from the depreciation in Sections 16.010 to 16.030 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in Sections 16.010 to 16.030.

G. A nursing facility which has reduced licensed bed capacity after the preceding January 1, shall be allowed to aggregate the applicable replacement cost new per bed limits based on the number of beds licensed prior to the reduction; and establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 4. The notification must include a copy of the delicensure request that has been submitted to the Commissioner of health.

SECTION 16.050 **Allowable debt.** For purposes of determining the property-related payment rate, the Department shall allow or disallow debt according to items A to F.

A. Debt shall be limited as follows:

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

(2) Working capital debt shall not be allowed.

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

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

(5) Any portion of the total allowable debt exceeding the appraised value as determined in Section 16.040 shall not be allowed.

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

(7) Debt associated with the appraised value, is subtracted form each facility's appraised value and the result is multiplied by 5.66%. The facility's interest expense, as limited by floating and absolute maximum rates is added.

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

A hospital-attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to Section 16.050, and allowable interest expense computed according to Section 16.070 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in Section 16.010.

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

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

E. Except as provided in item F, debt incurred as a result of loans between related organizations must not be allowed.

F. Debt meeting the conditions in Section 16.132 is allowable.

SECTION 16.060 **Limitations on interest rates.** The Department shall limit interest rates according to items A to C.

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

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

(2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under Section 16.050, item D.

C. For rate years beginning on July 1, 1985, and for rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

SECTION 16.070 **Allowable interest expense.** The Department shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under Section 16.050 and within the interest rate limits in Section 16.060.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or

replacement of those capital assets. For purposes of this item and Section 4.020, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

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

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in Sections 16.010 to 16.040. For a rate year beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense.

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

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

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

(1) The interest rate on the refinanced debt shall be limited under Section 16.060, item A.

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

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

SECTION 16.080 **Building capital allowance for owner-operated nursing facilities or nursing facilities with capital leases.** Except as provided in Section 16.140, for the rate years beginning after June 30, 1985, the building capital allowance for owner-operated nursing facilities or nursing facilities with capital leases must be computed as follows:

A. The rental factor is 5.33 percent. For the rate year beginning July 1, 1988 the rental factor

will be increased by 6.2% rounded to the nearest 100th percent or 5.66 percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined for the rate year beginning July 1, 1988.

B. The difference between the nursing facility's allowable appraised value determined under Sections 16.010 to 16.040 and the allowable debt determined in Section 16.050 is multiplied by the rental factor.

C. The amount determined in item B must be added to the total allowable interest expense determined under Sections 16.060 and 16.070.

D. Except as in item E, the amount determined in item C must be divided by 95 percent of capacity days.

E. If the average length of stay in the skilled level of care within a nursing facility is 180 days or less, the nursing facility shall divide the amount in item C by the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

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

F. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt are allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease do not exceed the rate otherwise paid.

SECTION 16.090 **Building capital allowance for nursing facilities with operating leases.** Except as provided in Section 16.140, for rate years beginning after June 30, 1985, the building capital allowance for nursing facilities with operating lease costs incurred for buildings must be paid as determined by items A to C.

A. The allowable appraised value of the nursing facility must be established according to Sections 16.010 to 16.040.

B. The allowable interest expense determined under Sections 16.060 and 16.070 and the allowable debt determined under Section 16.050 for the leased nursing facility must be considered zero.

C. Except as in item D, the building capital allowance must be the lesser of the operating lease expense divided by 95 percent of capacity days, or the allowable appraised value multiplied by the rental factor and then divided by 95 percent of capacity days.

D. A nursing facility with an average length of stay of 180 days or less shall use the divisor determined in Section 16.080, item E, instead of 95 percent of capacity days.

SECTION 16.100 **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

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

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

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility. For purposes of this item, a hospital-attached nursing facility shall use the allocation method in Section 16.010 to stepdown the historical cost of depreciable equipment.

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

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

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

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

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

D. Within each group determined in item C, the historical cost per bed for each nursing

facility determined in item B must be ranked and the median historical cost per bed established.

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

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

G. For the rate year beginning July 1, 1990, the Commissioner shall increase the nursing facility's equipment allowance established in items A to F by $.10 per resident day.

H. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation by the index in E.

SECTION 16.110 **Capacity days.** The number of capacity days is determined under items A to C.

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

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period. This adjustment has the effect of assigning a greater proportion of property costs to single bed rooms.

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

(1) The nursing facility shall agree not to request a private room payment in Section 18.030 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in Section 16.040.

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

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

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

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in clause (b) must be added to each total payment rate established in Section 18.010 to determine the nursing facility's single bedroom payment rates.

SECTION 16.120 **Capitalization.** For rate years after June 30, 1985, the cost of purchasing or repairing capital assets shall be capitalized under items A to D.

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

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

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

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

SECTION 16.130 **Determination of the property-related payment rate.** The Department shall determine the property-related payment rate according to items A to G.

A. Except as provided in Section 16.140, the building capital allowance of each nursing home shall be added to the equipment allowance.

B. For rate years beginning after June 30, 1986, the historical property-related cost per diem shall be the property-related payment rate established for the previous rate year unless the nursing facility's capacity days change. If the nursing facility's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing facility beds, a change in the election for computing capacity days as provided in Section 16.110, or a change in the number of days in the reporting year, the historical property related per diem must be recalculated using the capacity days for the reporting year in which the change occurred.

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

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

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

F. In the event of a change of ownership or reorganization of the provider entity occurring after June 30, 1985, the nursing facility's property-related payment rate must be the lesser of the property-related payment rate in effect at the time of sale or reorganization or the amount determined in item A. Changes in the property-related payment rate as a result of this item shall be effective on the date of the sale or reorganization of the provider entity. For the purposes of this subsection, the following types of transactions shall not be considered a sale or reorganization of a provider entity:

(1) The sale or transfer of a nursing facility upon death of an owner.

(2) The sale or transfer of a nursing facility due to serious illness or disability of an owner as defined under the social security act.

(3) The sale or transfer of the nursing facility upon retirement of an owner at 62 years of age or older.

(4) Any transaction in which a partner, owner, or shareholder acquires an interest or share of another partner, owner, or shareholder in a nursing facility business provided the acquiring partner, owner, or share has less than 50 percent ownership after the acquisition.

(5) A sale and leaseback to the same licensee which does not constitute a change in facility license.

(6) A transfer of an interest to a trust.

(7) Gifts or other transfers for no consideration.

(8) A merger of two or more related organizations.

(9) A transfer of interest in a facility held in receivership.

(10) A change in the legal form of doing business other than a publicly held organization which becomes privately held or vice versa.

(11) The addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing facility or the issuance of stock.

(12) An involuntary transfer including foreclosure, bankruptcy, or assignment for the benefit of creditors.

G. The property-related payment rate for a nursing facility which qualifies for the special reappraisal in Section 16.030, item A shall be determined according to subitems (1) to (2).

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

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

SECTION 16.132 **Special property-related payment provisions for certain leased nursing facilities.**

A. A nursing facility leased prior to January 1, 1986, and currently subject to adverse licensure action by the Minnesota Department of Health and whose ownership changes prior to July 1, 1990, shall be allowed a property payment rate equal to the lesser of its current lease obligation divided by its capacity days as outlined in Section 16.110, or the frozen property payment rate in effect for the rate year beginning July 1, 1989. For rate years beginning on or after July 1, 1991, the property related payment rate shall be its rental rate as computed using the previous owner's allowable principal and interest expense as allowed by the Minnesota Department of Human Services prior to that prior owner's sale and lease-back transaction of December 1985.

B. Notwithstanding other provisions in this attachment, a nursing facility licensed for 122 beds on January 1, 1998, and located in Columbia Heights has its property-related payment rate set under this section. The Department shall make a rate adjustment by adding $2.41 to the facility's July 1, 1997 property-related payment rate (which is effective for rate years beginning on or after July 1, 1998). The adjustment remains in effect so long as the facility's rates are set under this section. If the facility participates in the contractual alternative payment rate system of Section 22.000, the adjustment in this item is included in the facility's contract payment rate. If historical rates or property costs recognized under this section become the basis for future medical assistance payments to the facility under a managed care, capitation or other alternative payment system, the adjustment of this item will be included in the computation of the facility's payments.

SECTION 16.133 **Special property-related payment provisions for recently constructed nursing facilities.** For the rate years beginning on or after July 1, 1990 nursing facilities that on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement cost new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement cost new per bed limit divided by their capacity days from the preceding reporting year, plus their equipment allowance.

A nursing facility that is eligible for a property related payment rate under this section and whose property payment rate in a subsequent year is its rental per diem must continue to have its property related payment rates established for all future years based on the rental reimbursement formula. The Commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this section. If a nursing facility is eligible for a property related payment

rate under this section, and the nursing facility's debt is refinanced after October 1, 1988, the provisions of paragraphs (1) to (7) also apply to the property related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing facility's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital asset limit includes issuance costs that do not exceed seven percent of the debt refinanced, plus related issuance costs. For purposes of this section, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight line amortization of the refinancing costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation in subitem (2), if any.

(4) If the nursing facility's refinancing includes zero coupon bonds, the Commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of the annuity payments is added to the nursing facility's allowable annual principal and interest expense payment computed in subitem (3).

(6) The property related payment rate is equal to the amount in subitem (5) divided by the nursing facility's capacity days as determined in Section 16.110, for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this section, the previously outlined methodology for the calculation of property payment rates applies.

SECTION 16.136 **Property payment rates for rate years beginning on or after July 1, 1990.** For purposes of property-related reimbursement under this section, nursing facilities will be grouped according to the type of property related payment rate the Commissioner of Human Services for the

rate year beginning July 1, 1989. A nursing facility whose property rate was determined under full rental shall be considered group A. A facility whose property payment rate was determined under phase down to rental reimbursement shall be considered group B. A facility whose rate was determined under the phase up provisions will be considered group C.

A. For the rate year beginning July 1, 1990, a group A facility will continue to have its property-related payment rate determined in accordance with the provisions of Section 16.080.

B. For the rate year beginning July 1, 1990, a group B facility will receive a payment related rate equal to the greater of:

(1) 87% of the property related payment rate in effect on July 1, 1989; or

(2) the rental per diem calculated in accordance with the provisions of Section 16.080 and this section; or

(3) the sum of 100% of the nursing facilities allowable principal and interest expense; plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facilities capacity days.

C. For the rate year beginning July 1, 1990, a group C facility will have its property related payment rate calculated under the provisions of Section 16.130 item C and this section, except that its property related payment rate cannot exceed the lesser of its property related payment rate established for the rate year beginning July 1, 1989, multiplied by 116% or the rental per diem determined effective July 1, 1990.

D. The property related payment rate for a nursing facility that qualifies for a special reappraisal will have the applicable property related payment rate as calculated above and as adjusted in accordance with the provisions of Section 16.030.

E. Except as provided in Section 16.130, item F, and Section 16.132, a nursing facility that has a change of ownership or a reorganization of provider entity is subject to the provisions of Section 16.130, item F.

F. Except as provided in Section 16.133, a nursing facility will have its property related payment rate calculated according to items A to E. Those nursing facilities whose property related payment rates are calculated under the provisions of Section 16.133 will receive a property related payment rate equal to the greater of the rate calculated under Section 16.133 or that rate applicable under items A to E.

SECTION 16.1370 **Hold-harmless property-related rates.**

A. Terms used in Sections 16.1370 to 16.1378 shall be as defined in the plan. Capital assets for purposes of Sections 16.1370 to 16.1378 only means a nursing facility's buildings, attached fixtures, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

B. Except as provided in this section, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase or decrease in the nursing facility's rental rate will be determined under this plan. An incremental decrease with an effective date after June 30, 1993, must reduce the nursing facility's property related payment rate.

C. Notwithstanding Section 16.130, item F, a nursing facility that has a sale permitted under Section 16.1371 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under Section 16.1371. For rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase or decrease allowed under Section 16.1371.

D. For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989 that was sold during the cost reporting year ending September 30, 1991 (after relocating its beds from a separate nursing home to a building formerly used as a hospital) is its property-related rate before the sale plus:

(1) the incremental increase effective October 1, 1992 of 29 cents per day; and

(2) any incremental increases after October 1, 1992 calculated by using its rental rate, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location before relocating its beds.

Section 16.1371 **Limitations on sales of nursing facilities.**

A. For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property-related payment rate as established under Section 16.1370 shall be adjusted by either item B or C for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this Section.

B. If the nursing facility's property-related payment rate under Section 16.1370 prior to sale is greater than the nursing facility's rental rate under this plan prior to sale, the nursing facility's property-related payment rate after sale shall be the greater of its property-related payment rate under Section 16.1370 prior to sale or its rental rate under this plan calculated after sale.

C. If the nursing facility's property-related payment rate under Section 16.1370 prior to sale is equal to or less than the nursing facility's rental rate under this plan prior to sale, the nursing facility's property-related payment rate after sale shall be the nursing facility's property-related payment rate under Section 16.1370 plus the difference between its rental rate calculated under this plan prior to sale and its rental rate calculated under this plan calculated after sale.

D. For purposes of this section, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock purchase of a nursing facility or any of the following transactions:

(1) a sale and leaseback to the same licensee that does not constitute a change in facility license;

(2) a transfer of an interest to a trust;

(3) gifts or other transfers for no consideration;

(4) a merger of two or more related organizations;

(5) a change in the legal form of doing business, other than a publicly held organization that becomes privately held or vice versa;

(6) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing home or the issuance of stock; and

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

E. For purposes of this item, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Section 1.030, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under 42 U.S.C. §423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this item otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to

Section 16.050, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time the seller forgives the related organization debt allowed under this item for other than equal amount of payment on that debt, then the buyer shall pay to the State the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the rights to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Section 16.070, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

F. For purposes of this section, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

G. The effective day for the property-related payment rate determined under this section shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later.

H. Notwithstanding Section 16.050, item A, subitems (3) and (4), and Section 16.050, items E and F, the Commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of subitems (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The Commissioner shall compute the allowed inflation as described in item I.

I. For purposes of computing the amount of allowed inflation, the Commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the Commissioner shall substitute the index in Section 16.040, item A, subitem (4), or such other index as the secretary of the health care financing administration may designate;

(2) the amount of allowed inflation to be applied to the capital assets in item H, subitems (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in item ~~G~~ H, subitems (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month preceding the effective date of sale.

J. If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the Commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the Commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

K. The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

SECTION 16.1372 **Capital repair and replacement cost reporting and rate calculation.**

For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in items A to E.

A. Notwithstanding Section 16.120, the costs of any of the following items, not included in

the equity incentive computation under Section 16.1373 or reported as a capital asset addition under Section 16.375, item B, including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category when the cost of the item exceeds $500:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement

B. Notwithstanding Section 16.120, the repair or replacement of a capital asset not included in the equity incentive computations under Section 16.1373 or reported as a capital asset addition under Section 16.1375, item B, must be reported in the capital repair and replacement cost category when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

C. To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under Section 16.1371, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in Section 16.1371, item F, for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in Section 16.040, item A, subitem (4). For purposes of this section, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

D. Capital repair and replacement costs under this Section shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

E. If costs otherwise allowable under this section are incurred as the result of a project

approved under the moratorium exception process or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under Sections 16.1373 or 16.1374 as appropriate.

SECTION 16.1373 **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in items A to D. This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

A. An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in items B and C and divided by the nursing facility's occupancy factor under Section 16.090, items C or D. This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in item D or Section 16.1374. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in this plan.

B. The equity incentive factor shall be determined under subitems (1) to (4):

(1) divide the initial allowable debt in item A by the initial historical cost of the capital asset additions referred to in item A, then cube the quotient,

(2) subtract the amount calculated in subitem (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in subitem (2) by the amount calculated in subitem (3).

C. The equity incentive payment rate shall be limited to the term of the allowable debt in item A, not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility

under Section 16.1371 shall terminate application of the equity incentive payment rate effective on the date provided in Section 16.1371, item F, for the sale.

D. A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this section and not receiving the property-related payment rate adjustment in Section 16.1374, shall receive the incremental change in the nursing facility's rental rate as determined under this plan. The incremental change shall be added to the nursing facility's property-related payment rate. The effective date of this incremental change shall be the first day of the month following the month in which the addition or replacement is completed.

SECTION 16.1374 **Special provisions for exceptions.**

A. Notwithstanding Section 16.030 for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that has completed a renovation, replacement, or upgrading project approved under the moratorium exception process, or a nursing facility that has received a statutory exception after June 30, 1995, except for a 115 bed county owned nursing facility which has received a statutory exception in 1993, shall be reimbursed for costs directly identified to that project as provided in Section 16.1373 and this section.

B. Notwithstanding Section 16.050, item A, subitems (1) and (3), and Section 16.070, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed ten percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

C. Debt incurred for costs under item B is not subject to Section 16.050, item A, subitems (5) or (6).

D. The incremental increase in a nursing facility's rental rate, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this section shall be added to

its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

E. Notwithstanding Section 16.040, item A, subitem (4) for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Section 16.040, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in Section 16.040, item A, subitem (4) beginning January 1, 1993.

F. The Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided under the moratorium exceptions process. "Certified bed" means a nursing home bed or a boarding care bed certified by the Commissioner of health for the purposes of the medical assistance program under United States Code, title 42, sections 1396 et seq.

The Commissioner, in coordination with the Commissioner of the Minnesota Department of Health, shall deny any request to issue a nursing home license to a facility if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the Commissioner of the Minnesota Department of Health must not approve any construction project whose costs exceed $1,000,000 plus inflation added annually unless:

(1) Any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(2) The project:

(a) has been approved through the moratorium exception process described in state law;

(b) meets an exception described in the moratorium exception state law;

(c) is necessary to correct violations of state or federal law issued by the

Commissioner of the Minnesota Department of Health;

(d) is necessary to repair or replace a portion of the facility that was destroyed by fire, lightning, or other hazards provided that the provisions of statute governing replacement are met;

(e) as of May 1, 1992, the facility has submitted to the Commissioner of the Minnesota Department of Health written documentation evidencing that the facility meets the "commenced construction" definition as specified in Section 1.030, or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and has include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(f) is being proposed by a licensed nursing facility that is not certified to participate in the Medical Assistance Program and will not result in new licensed or certified beds.

G. Prior to the final plan approval of any construction project, the Commissioner of the Minnesota Department of Health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the Commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the Commissioner of the Minnesota Department of Human Services, the total project construction costs for the construction project shall be submitted to the Commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the Commissioner of Human Services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

Project construction costs includes the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for facility capital asset additions, replacements, renovations, remodeling projects, construction site preparation costs and related soft costs are more than the threshold for additions and replacements in Section 16.1373. "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Technology and depreciable equipment are included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value. Debt incurred for

purchase of technology and depreciable equipment is included as allowable debt for purposes of Section 16.050, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt is treated as provided in item B. Written election must be included in the facility's request for the rate change related to the project, and this election may not be changed.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in item F, subitem (2), clauses (a) to (f), the dollar threshold is $1,000,000 plus inflation added annually. For projects authorized after July 1, 1993, under item F, subitem (2), clause (a), the dollar threshold is the cost estimate submitted with a proposal for an exception to the state's moratorium law, plus inflation as calculated according to section 16.1378. For projects authorized under (b) to (d), the dollar threshold is the itemized estimate project construction costs submitted to the Commissioner of Health at the time of final plan approval, plus inflation as calculated according to Section 16.1378.

H. For purposes of this section, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocated beds from three- and four-bed wards.

(1) For total replacement projects completed on or after July 1, 1992, the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, shall be computed by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs.

(2) If the new nursing facility has decreased its licensed capacity, the aggregate replacement cost new per bed limit in Section 16.040, item G, shall apply.

(3) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subitem, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (a) to (c):

(a) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage;

(b) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant;

(c) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (a) by clause (b).

(4) In the case of either type of total replacement as authorized under statutory exceptions or moratorium process exceptions, the provisions of this subitem will also apply. For purposes of the moratorium exception authorized by statutory exception which permits the relocation of 117 beds from a 138 bed nursing home to a former hospital, if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

I. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under Section 22.061, the replacement-costs-new per bed limits are $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Beginning January 1, 2000, these amounts must be adjusted annually as specified in item E.

J. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H, for a 96-bed nursing facility in Carlton county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the $1,000,000 plus inflation limit set forth in state law. The deadline for total replacement of this 96-bed nursing facility is May 31, 2000.

K. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. These amounts will be adjusted annually, beginning January 1, 2001. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the $1,000,000 plus inflation limit set forth in state law. If the other

requirements in state law governing approval of requests for amendments to moratorium exception projects are met, the Department of Health may waive the requirement that the nursing facility's request for an amendment to its moratorium exception project design may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent.

L. For a renovation authorized under moratorium process exceptions for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of item D shall be $8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest are increased according to the incremental increase.

M. Effective July 1, 2001, the Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services may:

(1) license and certify beds in nursing facilities that have undergone replacement or remodeling as part of a planned closure pursuant to Section 20.027;

(2) license and certify a total replacement project of up to 124 beds in facilities significantly damaged in the flood of 1997 when the damage was not apparent until years later. The operating cost payment rates for a new facility are determined pursuant to the interim and settle-up payment provisions of Section 12.000 and the payment provisions of this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after the settle-up cost report is filed. Property-related payment rates are determined pursuant to this Attachment, taking into account any federal or state flood-related loans or grants provided to the facility;

(3) allow facilities that provide residential services for the physically handicapped with less than 60 beds to transfer nine beds to provide residential services, provided that the total number of licensed and certified beds does not increase;

(4) allow non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility to build replacement facilities of up to 120 beds, provided the new facility is located within four miles of the existing facility and is in the same county. Operating and property rates are determined pursuant to this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after settle-up; and

(5) allow organizations that operate non-profit facilities in the county with the fewest beds per 1000 for age 65 and over to obtain up to 98 beds of a closing non-profit facility. All transferred beds will be put on layaway status, held in the name of the receiving facility. The layaway adjustment provisions of Section 20.100 do not apply. A receiving facility may only remove

the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. A receiving facility must receive authorization before removing these beds from layaway status.

(6) effective July 1, 2006, allow an Anoka County nursing facility that had placed beds on layaway status as part of a previous statutory exception to the moratorium to remove beds from that status if the removal is part of a project approved by the commissioner of Human Services under the competitive moratorium exception process.

N. Effective July 1, 2003, the Department of Health, in coordination with the Department of Human Services, may approve the renovation, replacement, upgrading, or relocation of facilities that meet the following conditions:

(1) license and certify 80 beds in city-owned facilities to be constructed on the site of new city-owned hospitals that replace existing 85-bed facilities attached to existing hospitals. The threshold allowed is the amount that was allowed under the moratorium exception process; and

(2) license and certify 29 beds to be added to 69-bed facilities, provided that:

(a) the 29 beds are transferred from active or layaway status from facilities that have 235 beds on April 1, 2003, when both facilities are located in the same county; and

(b) the licensed capacity of 235-bed facilities must be reduced to 206 beds, and the payment rate will not be adjusted as a result of the transfer.

The operating payment rate of 69-bed facilities adding 29 beds after completion of a project will be the same as it was on the day before the day the beds are licensed and certified. Projects will not begin unless they are approved and financed under the moratorium exception process.

O. Effective August 1, 2004, the Department of Health, in coordination with the Department of Human Services, may approve the renovation, replacement, upgrading, or relocation of facilities that meet the following conditions:

(1) license and certify 60 new beds, provided that:

(a) 45 of the new beds are transferred from facilities that have 45 beds in the same county under common ownership that have closed, and 15 of the new beds are transferred from facilities that have 182 beds under common ownership;

(b) the Department continues to have authority under Section 20.027 to

negotiate budget-neutral planning facility closures; and

(c) money is available from planned closures of facilities under common ownership to make implementation of this item budget-neutral.

The bed capacity of the 182-bed facilities under common ownership is reduced to 167 beds following the transfer.

P. Effective July 1, 2006, the Department of Health, in coordination with the Department of Human Services, may license and certify up to 80 beds transferred from an existing state-owned nursing facility in a county to a new facility located on the grounds of the existing state-owned facility from which they are transferred. The operating cost payment rates for the new facility shall be determined based on the interim and settle up payment provisions of Section 12.000 and the reimbursement provisions of Sections 1.000 through 21.000. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 shall be adjusted for inflation as provided in section 22.060 so long as the facility has a contract under Section 22.000.

Q. Effective for rate adjustments beginning July 1, 2006, nursing facilities paid by the prospective rate-setting methodology described in Sections 1.000 through 21.000 that commenced a construction project on or after October 1, 2004, and do not have a contract under the contractual rate-setting methodology described in Section 22.000 by September 30, 2006, are eligible to request a property rate adjustment under Section 16.000 through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

R. Upon Steele County completing asset transfers and constructing a new nursing facility, its present nursing facility will be allowed to relocate 80 beds. For the first three years of operation of the new facility, the property payment rate shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor as determined in section 16.080, multiplied by the historical percentage of medical assistance resident days.

For subsequent years, the property payment rate shall be adjusted for inflation as provided in section 22.060 so long as the facility has a contract under Section 22.000.

S. Effective July 1, 2008, a nursing facility providing specialty care in Minneapolis may close and relocate beds to a new facility in Robbinsdale under common ownership if approved under the moratorium exception at Minnesota Statutes (2008) §144.073.

T. Effective May 14, 2010, nursing facility bed consolidation and relocation with integration of these services with other community-based services under a Communities-for-a-Lifetime pilot program is allowed for a new site in Goodhue County. These changes will have a comprehensive plan to create innovative responses to the aging population. Eighty beds in the city of Red Wing shall be transferred from the downsizing and relocation of an existing 84-bed, hospital-owned nursing facility and the entire closure or downsizing of beds from a 65-bed nonprofit nursing facility in the community resulting in the delicensure of 69 beds in the two existing facilities. The closure of the 69 beds shall not be eligible for a planned closure rate adjustment under section 20.027. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 22.061. The property payment rate for the first three years of operation of the new facility shall be
increased by an amount as calculated according to items (i) to (vi):
(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;
(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365. The hospital-owned nursing facility weighted average payment rate is determined by multiplying the facility's current total payment rates for each of the 36 RUG payment levels by the corresponding total resident days according to the most recently desk-audited cost report. Sum the products of these calculations and the resident days. Divide the sum of the products by the sum of the resident days to

compute the weighted average payment rate;
(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;
(iv) subtract the amount in item (iii) from the amount in item (ii);
(v) multiply the amount in item (iv) by 48.5 percent; and
(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 16.080, items D & E, multiplied by the historical percentage of medical assistance resident days. For subsequent years, the adjusted property payment rate shall be adjusted for inflation as provided in section 22.060 items C to F, as long as the facility has a contract under section 22.

U. Effective June 28, 2011, a 137-bed nursing facility in Bloomington that applied for and was selected for a moratorium exception project is allowed to increase its moratorium-exception project rate adjustment from $14.42 to $19.33.

SECTION 16.1375 **Appraisals; updating appraisals, additions, and replacements.**

A. Notwithstanding Sections 16.010 to 16.030, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this section.

B. Notwithstanding Section 16.020, for rate years beginning after June 30, 1993, the Commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value. The Commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in Section 16.040, item A, subitem (4), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the Commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value. In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Section 16.1376 **Refinancing incentive.**

A. A nursing facility that refinances debt after May 30, 1992, in order to save in interest expense payments as determined in subitems (1) to (5) may be eligible for the refinancing incentive

under this Section. To be eligible for the refinancing incentive, a nursing facility must notify the Commissioner in writing of such a refinancing within 60 days following the date on which the refinancing occurs. If the nursing facility meets these conditions, the Commissioner shall determine the refinancing incentive as in subitems (1) to (5).

(1) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, remaining on the debt to be refinanced, and divide this amount by the number of years remaining for the term of that debt.

(2) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, for the new debt, and divide this amount by the number of years for the term of that debt.

(3) Subtract the amount in subitem (2) from the amount in subitem (1), and multiply the amount, if positive, by .5.

(4) The amount in subitem (3) shall be divided by the nursing facility's occupancy factor under Section 16.090, items C or D.

(5) The per diem amount in subitem (4) shall be deducted from the nursing facility's property-related payment rate for three full rate years following the rate year in which the refinancing occurs. For the fourth full rate year following the rate year in which the refinancing occurs, and each rate year thereafter, the per diem amount in subitem (4) shall again be deducted from the nursing facility's property-related payment rate.

B. An increase in a nursing facility's debt for costs in Section 16.1375, item B, subitem (2), including the cost of refinancing the issuance or financing costs of the debt refinanced resulting from refinancing that meets the conditions of this section shall be allowed, notwithstanding Section 16.050, item A, subitem (6).

C. The proceeds of refinancing may not be used for the purpose of withdrawing equity from the nursing facility.

D. Sale of a nursing facility under Section 16.1371 shall terminate the payment of the incentive payments under this section effective the date provided in Section 16.1371, item F, for the sale, and the full amount of the refinancing incentive in item A shall be implemented.

E. If a nursing facility eligible under this section fails to notify the Commissioner as required, the Commissioner shall determine the full amount of the refinancing incentive in item A, and shall deduct one-half that amount from the nursing facility's property-related payment rate effective the first day of the month following the month in which the refinancing is completed. For the next three full

rate years, the Commissioner shall deduct one-half the amount in item A, subitem (5). The remaining per diem amount shall be deducted in each rate year thereafter.

F. The Commissioner shall reestablish the nursing facility's rental rate following the refinancing using the new debt and interest expense information for the purpose of measuring future incremental rental increases.

SECTION 16.1377 **Special property rate setting.**
For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related payment rate for a nursing facility approved for total replacement under the moratorium exception process through an addition to another nursing facility shall have its property-related rate under Section 16.1370 recalculated using the greater of actual resident days or 80 percent of capacity days. This rate shall apply until the nursing facility is replaced or until the moratorium exception authority lapses, whichever is sooner.

SECTION 16.1378 **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the Commissioner shall annually update the dollar thresholds in Sections 16.1373, and 16.1374, by the inflation index referenced in Section 16.090, item A, subitem (4).

SECTION 16.138 **Plant and maintenance costs.** For the rate years beginning on or after July 1, 1987, the Department shall allow as an expense in the reporting year of occurrence the lesser of the actual allowable plant and maintenance costs for supplies, minor equipment, equipment repairs, building repairs, purchased services and service contracts, except for arms-length service contracts whose primary purpose is supervision, or $325 per licensed bed.

SECTION 16.140 **Determination of interim and settle-up payment rates.** The Department shall determine interim and settle-up payment rates according to items A to J.

A. A newly-constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the Department to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in Sections 1.000 to 19.050 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with Sections 1.000 to 19.050. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly-constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly-constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim

payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined under the temporary rule then in effect, except that capital assets must be classified under Sections 1.000 to 19.050.

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

(1) At least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed and upon receipt of written application from the nursing facility, the Department shall establish the nursing facility's appraised value according to Sections 16.010 and 16.040.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to Sections 16.050 and 16.070.

(3) The interim building capital allowance must be determined under Section 16.080 or 16.090.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with Section 16.100 which is in effect on the effective date of the interim property-related payment rate.

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

(6) Anticipated resident days may be used instead of 95% percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction before July 1, 1985, is determined under the temporary rule then in effect. The property-related payment rate for the rate year beginning July 1 following the nine-month period is determined under Sections 16.000 to 16.140.

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

(1) The appraised value determined in item D, subitem (1) must be updated in accordance with Section 16.020, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with Sections 16.050, 16.060, and 16.070.

(3) The settle-up building capital allowance shall be determined in accordance with Section 16.080 or 16.090.

(4) The equipment allowance shall be updated in accordance with Section 16.100 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

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

(6) Resident days may be used instead of 95% percent capacity days.

G. The property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 95% percent capacity days must be used.

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

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

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

SECTION 17.000 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS

The total real estate taxes and actual special assessments and payments permitted under Section 5.000, item CC must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments. Special assessments are reimbursed as paid by the facility except that facilities that incur special sewer assessments as part of their utility bill may reclassify that amount to the real estate tax and special assessment cost category. Real estate taxes are reimbursed based on the real estate tax assessed for the calendar year following the reporting year and are adjusted to account for the difference between the tax year and the reporting year in which the taxes are due. This adjustment is equivalent to ½ the increase or decrease in the property tax liability of a facility. The Commissioner shall include the reported actual or payments in lieu of real estate taxes of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount that a nursing facility would have paid to a city or township and county for fire, police, sanitation an road maintenance costs had real estate taxes been levied on that property for those purposes.

SECTION 17.010 **Payment for long term care consultation fees.** The estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs reported are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate under Section 18.000. However, these costs are not included in the calculation of either the care related or other operating cost limits, nor are they indexed to account for anticipated inflation.

SECTION 17.020 **Payment for increase in Department of Health license fees.** A nursing facility's case mix payment rates include an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

SECTION 18.000 COMPUTATION OF TOTAL PAYMENT RATE

SECTION 18.010 **Total payment rate.** The total payment rate is the sum of the operating cost payment rate (including any efficiency incentive calculated under Sections 11.030 and 11.040, and the preadmission screening cost per diem calculated under Section 17.010), the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

SECTION 18.020 **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate unless the total payment rate being adjusted was subject to the private payment rate limitation.

SECTION 18.030 **Private room payment rate.** A private room payment rate of 115 percent of the

established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in Section 16.110, item C. Effective October 1, 2009, the private room payment rate is 111.5 percent of the total payment rate. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the Department on the basis of medical necessity.

SECTION 18.040 **Adjustment of total payment rate.** If the Department finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the Department shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the Department the entire overpayment within 120 days of receiving the written notification from the Department. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under Section 19.000, any payments owed by the nursing facility or by the Department must be made within 120 days of written notification to the nursing facility of the Department's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the Department's ruling on the appeal. The annual interest rate charged must be the rate charged by the Commissioner of the department of revenue for late payment of taxes, which is in effect on the 121st day after the written notification.

SECTION 19.000 APPEAL PROCEDURES

SECTION 19.010 **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this attachment and reimbursement rules of the Department if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors under Section 22.130. Appeals must be filed in accordance with procedures in this section.

SECTION 19.020 **Filing an appeal.** To appeal, the provider will file with the Department a written notice of appeal; the appeal must be postmarked or received by the Commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required

by the Commissioner.

SECTION 19.030 **Contested case procedures appeals review process.** Effective August 1, 1997, the following apply.

A. Effective for desk audit appeals for rate years beginning on or after July 1, 1997, and for field audit appeals filed on or after that date, the Commissioner shall review appeals and issue a written appeal determination on each appeals item within one year of the due date of the appeal. Upon mutual agreement, the Commissioner and the provider may extend the time for issuing a determination for a specified period. The Commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

B. In reviewing the appeal, the Commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the Commissioner prior to the issuance of the appeal determination within six months of the date the appeal was received by the Commissioner. Written requests for conferences must be submitted separately from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

C. For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the Commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the Commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the Commissioner for that appeal item. The Commissioner shall refer any contested case demand to the Office of the Attorney General.

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

E. Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment.

F. The Commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

G. Effective August 1, 1997, the Commissioner may use the procedures described in this section to resolve appeals filed before July 1,1997.

SECTION 19.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 19.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

B. When an award is made to the Department under this section, attorney fees must be calculated at the cost to the Department. When an award is made to a provider under this section, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

C. In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value

of the issue, the complexity, of the issue, and other factors deemed appropriate by the administrative law judge.

D. When the Department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's cost report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

G. If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the Department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the Commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

H. Amounts collected by the Commissioner pursuant to this section must he deemed to be recoveries.

I. This section applies to all contested case proceedings set on for hearing by the Commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

SECTION 19.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and explained on the provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the Department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition the provider shall inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 20.000 SPECIAL EXCEPTIONS TO THE PAYMENT RATE

Section 20.010 **Swing beds.** Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed unless:

A. The facility in which the swing bed is located is eligible as a sole community provider, as defined in 42 CFR §412.92.

B. As of January 1, 2004, the facility in which the swing bed is located had an agreement with the Department to provide medical assistance swing bed services. This exception applies to swing bed services provided on or after July 1, 2005.

C. The facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute-care beds.

D. Nursing facility care has been recommended for the person by a long-term care consultation team.

E. The person no longer requires acute-care services.

F. No nursing facility beds are available within 25 miles of the facility.

G. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interest of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

The daily medical assistance payment rate for nursing care for a person in a swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually on July 1 of each year.

SECTION 20.020 **Negotiated rates for services for ventilator-dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator-dependent person if:

A. Nursing facility care has been recommended for the person by a long-term care consultation team.

B. The person has been hospitalized and no longer requires inpatient acute care hospital services.

C. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator-dependent person based on documentation of supplies used and time spent on caring for the resident, up to the maximum rate described below. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest RUGs rate. For persons initially admitted to a facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the highest RUGs rate. The adjustment may be negotiated with a resident who is ventilator-dependent, for that resident.

Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons, whichever is later, the operating payment rates for residents meeting the ventilator-dependent criteria above in A-C, in a nursing facility in Waseca county that on February 1, 2007, was licensed for 70 beds and reimbursed under Sections 1.000 to 22.000 or pursuant to Section 22.000, shall be 300 percent of the facility's highest RUG rate.

SECTION 20.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 20.026 **Interim closure payments for nursing facilities designated for closure under an approved closure plan and special rate adjustments for nursing facilities remaining open under an approved closure plan.** Instead of payments pursuant to Sections 1.000 to 21.000 or pursuant to the prospective rate-setting methodology in Section 22.000, the Department may approve a closure plan or a phased plan, permitting certain nursing facilities to receive interim closure payments or special rate adjustments.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure plan" means a system to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other nursing facilities. A closure plan may be submitted by nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities. Approval of a closure plan expires 18 months after approval, unless commencement of closure has occurred at all nursing facilities designated for closure under the plan.

(2) "Commencement of closure" means the date the Department of Health is notified of a planned closure, as part of an approved closure plan.

(3) "Completion of closure" means the date the final resident of a facility designated for closure in a closure plan is discharged.

(4) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved closure plan.

(5) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(6) "Special rate adjustment" means an increase in a nursing facility's operating rates. The special rate adjustment for each facility will be allocated proportionately to the various rate per diems included in that facility's operating rate.

B. The Department will not approve a closure plan or a phased plan unless it determines that projected state savings equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs relative to the plan. To achieve cost neutrality, costs may only be offset against savings that occur within the same state fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan.

C. Interim closure payments. To pay interim closure payments, the Department will:

(1) Apply the interim and settle-up rate provisions of Section 12.000 to include facilities covered under this section, effective from commencement of closure to completion of closure;

(2) Notwithstanding Section 16.140, item B, extend the length of the interim period, but no longer than 12 months;

(3) Limit the amount of payable expenses related to the acquisition of new capital assets;

(4) Prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the Department;

(5) Establish as the aggregate administrative operating cost limitation for the interim period the actual aggregate administrative operating costs for the period immediately before commencement of closure that is of the same duration as the interim period;

(6) Require the retention of financial and statistical records until it has audited the

interim period and the settle-up rate;

(7) Make aggregate payments under this section for the interim period up to the level of the aggregate payments for the period immediately before to commencement of closure that is of the same duration as the interim period; and

(8) Change any other provision to which all parties to the plan agree.

D. As part of a phased plan, a nursing facility may receive a special rate adjustment The special rate adjustment may be received under more than one phase of the closure plan, and the cost savings from the closure of the nursing facility designated for closure may be applied as an offset to the subsequent costs of more than one phase of the plan. If a facility is proposed to receive a special rate adjustment or provide cost savings under more than one phase of the plan, the proposal must describe the special rate adjustments or cost savings in each phase of the plan.

(1) The special rate adjustment is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure under the closure plan.

(2) For purposes of a phased plan, the special rate adjustment for each phase is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure in that phase of the plan.

SECTION 20.027 **Planned closure rate adjustments under an approved closure plan.** Between August 1, 2001, and June 30, 2003, the Department may approve planned closures of up to 5,140 nursing facility beds, less the number of beds delicensed in facilities during the same period without approved closure plans or that have notified the Minnesota Department of Health of their intent to close without an approved closure plan. Beginning July 1, 2004, the Department may negotiate planned closures only if the proposals are budget neutral to the state.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure" means the cessation of operations of a facility and delicensure and decertification of all beds within the facility.

(2) "Closure plan" means a plan to close a facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities. A closure plan is submitted to the Department by a facility. Approval of a closure plan expires 18 months after approval, unless commencement of closure has begun.

(3) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as part of an approved closure plan.

(4) "Completion of closure" means the date on which the final resident of a facility designated for closure in an approved closure plan is discharged.

(5) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

B. Closure rate adjustment calculation. The Department will calculate the planned closure rate adjustment according to the following:

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080 for planned closure rate adjustments negotiated or effective before March 1, 2006. Beginning March 1, 2006, the amount available is the net reduction of nursing facility beds mulitiplied by a negotiated closure rate adjustment factor. For planned closures approved after June 30, 2009, a per-bed amount of $2,080 is allowed for a nursing facility planned bed closure and the rate negotiation process is eliminated. Beginning November 1, 2011, applications will no longer be accepted for planned closure rate adjustments.

(2) the total number of beds in the facility or facilities receiving the planned closure rate adjustment are identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

C. A planned closure rate adjustment is effective on the first day of the month following completion of closure of a facility designated for closure in the application and becomes part of the facility's total operating payment rate.D. A facility or facilities paid pursuant to this Attachment with a closure plan may assign a closure rate adjustment to another facility or facilities that are not closing or, in the case of partial closure, to the facility undertaking the partial closure. A facility may also elect to have a closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that is closing is located.

Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the Department, may assign a planned closure rate adjustment (including assigning the amount calculated

under item B to themselves) if:

(1) they are delicensing no more than five beds, or less than six percent of their total licensed bed capacity, whichever is greater;

(2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and

(3) have not delicensed beds in the prior three months.

If a facility delicenses six or more beds, or six percent or more of its total licensed bed capacity, whichever is greater, and does not have an approved closure plan or is not eligible for the adjustment calculated in item B, the Department calculates the amount the facility would have been eligible to assign and uses this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that delicensed beds is located.

E. Applicants may use the planned closure rate adjustment to allow for:

(1) a property payment for a new facility;

(2) an addition to an existing facility; or

(3) as an operating payment rate adjustment.

F. A facility receiving a planned closure rate adjustment is eligible for any other rate adjustments under this Attachment.

G. A facility that receives a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to item B.

H. If the per bed dollar amount specified in item B, subitem (1) is increased, the Department will recalculate planned closure rate adjustments for facilities that delicense beds to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased. The removal of the limit in item B, subitem (1) does not constitute an increase.

I. Upon the request of a facility that is completely ceasing operations, the Department may increase the total payment rates of that facility by 50%. This rate increase is to reimburse

relocation costs or other costs related to facility closure, may be in effect for up to 60 days, and cannot begin until the number of residents in the closing facility is less than or equal to 90% of its licensed capacity.

J. After a facility that elected a 50 % rate increase under paragraph I has ceased operations, the Department will delay the implementation of a closure rate adjustment computed under paragraphs A. to H. to recover the Medicaid-related costs of the rate increase given under paragraph I.

K. A planned closure rate adjustment shall be approved for an eight-bed facility in Big Stone County for reassignment to a 50-bed facility within the county.

SECTION 20.030 **Facility serving exclusively the physically handicapped.** Nursing facilities that serve physically handicapped individuals and which have an average length of stay of less than one year are limited to 140% of the other-operating-cost limit for hospital attached nursing facilities. Other facilities serving physically handicapped individuals but whose average length of stay is not less than one year have a limit of 105 percent of the appropriate hospital attached limit.

SECTION 20.035 **Hospital-attached nursing facilities.** A hospital-attached nursing facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

A hospital-attached nursing facility is a facility which meets the criteria in items A, B, or C.

A. A nursing facility recognized by the Medicare Program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-attached nursing facilities under the Medicare Program is a hospital-attached nursing facility.

B. A nursing facility which, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, and which has applied for hospital-based nursing facility status under the Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, is considered a hospital-attached nursing facility for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application.

(1) The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare Program's hospital-based nursing facility status been granted to the nursing facility.

(2) If the nursing facility is denied hospital-based nursing facility status under the

Medicare Program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

C. The surviving nursing facility of a nonprofit or community operated hospital-attached nursing facility which suspended operation of the hospital is considered, at the option of the facility, a hospital-attached nursing facility for five subsequent rate years. In the fourth year the facility will receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility will receive 30 percent of the difference.

D. For rate years beginning on or after July 1, 1995, a nursing facility is considered a hospital-attached nursing facility for purposes of setting payment rates under this attachment if it meets the above requirements, and: (1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or (2) the nursing facility was recognized by the Medicare Program as hospital attached as of January 1, 1995 and this status has been maintained continuously.

SECTION 20.040 **Receivership.**

A. The Department in consultation with the Department of Health may establish a receivership fee that exceeds a nursing facility payment rate when the Commissioner of Health or the Commissioner of Human Services determines a nursing facility is subject to the receivership provisions. In establishing the receivership fee payment, the Commissioner must reduce the receiver's requested receivership fee by amounts that the Commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the nursing facility. If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee payment shall be set according to subitems (1) and (2) and payment shall be according to subitems (3) through (5).

(1) The receivership fee per diem is determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the Department has established a payment rate or the estimated resident days in the projected receivership fee period.

(2) The receivership fee per diem shall be added to the nursing facility's payment rate.

(3) Notification of the payment rate increase must meet the requirements for the notice to private paying residents.

(4) The payment rate in item C for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions.

(5) The Department may elect to make a lump sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the Department and the receiver or the managing agent shall agree to a repayment plan.

B. Upon receiving a recommendation from the Commissioner of Health for a review of rates, the Commissioner shall grant an adjustment to the nursing facility's payment rate. The Commissioner shall review the recommendation of the Commissioner of Health, together with the nursing facility's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing facility staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the Commissioner determines that the deficiency cannot be corrected or the need cannot be met, the Commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the Commissioner's review by the nursing facility's actual resident days from the most recent desk-audited cost report.

C. If the Department has established a receivership fee per diem for a nursing facility in receivership under item A or a payment rate adjustment under item B, the Department must deduct these receivership payments according to subitems (1) to (3).

(1) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within two weeks of the Department's written request, the Department shall compute the resident days by prorating the facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(2) The amount determined in item A must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(3) The per diem amount in item B shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provision of item G apply.

D. The Commissioner of Health may request the Commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The Commissioner, in consultation with the Commissioner of Health, may reestablish the receivership fee payment when the

Commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment apply to the reestablishment process.

E. The Commissioner of Health shall recommend to the Commissioner a review of the rates for a nursing home or boarding care home that participates in the Medical Assistance Program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the Commissioner of Health determines that a review of the rate is needed, the Commissioner shall provide the Commissioner of Human Services with: (1) a copy of the order or determination that cites the deficiency or need; and (2) the Commissioner's recommendation for additional staff and additional annual hours by type or employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

F. Downsizing and Closing nursing facilities. If the nursing facility is subject to a downsizing to closure process during the period of receivership, the Commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The Commissioner of Health and the Commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

G. Sale or transfer of a nursing facility in receivership after closure.

(1) Upon the subsequent sale or transfer of a nursing facility in receivership, the Commissioner must recover any amounts paid through payment rate adjustments under item F which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the Commissioner within 60 days after the Commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(2) If a nursing facility with payment rates subject to item F, subitem (1) is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate

year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

Upon the subsequent sale or transfer of the nursing facility, the department may recover amounts paid through payment rate adjustments under this section. The buyer or transferee will repay this amount to the department within 60 days after the department notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay

resident paid through payment rate adjustment.

SECTION 20.050 **Medicare upper payment limit rate adjustment.** In the event that the aggregate payment rates determined under this plan exceed the Medicare upper payment limit established at 42 CFR § 447.272, a rate adjustment will be determined as follows:

A. Aggregate the payment rates determined under this plan.

B. Determine the Medicare upper payment limit in accordance with 42 CFR §447.272.

C. Subtract item A from item B.

D. If item C exceeds zero, divide the amount in item C by total statewide nursing facility resident days during the rate year in which item C exceeds zero.

E. Subtract item D from the rate otherwise determined under this plan.

SECTION 20.060 **Employee scholarship costs and training in English as a second language (ESL).**

A. For the rate years beginning July 1, 2001 and July 1, 2002, the Department will provide to each nursing facility reimbursed pursuant to Sections 1.000 to 21.000 or pursuant to Section 22.000 a scholarship per diem of .25 to the total operating payment rate to be used for employee scholarships and to provide job-related training in ESL.

B. For rate years beginning on or after July 1, 2003, the .25 scholarship per diem is removed from the total operating payment rate, and the scholarship per diem is based on actual costs. In calculating the per diem, only costs related to tuition and direct educational expenses are permitted.

SECTION 20.070 **Alternative to Phase-in of Rebasing for Publicly-Owned Nursing Facilities**

(a) For services delivered between October 1, 2011, and September 30, 2015, nursing facilities whose physical plant is owned by a city, county, or hospital district may enter into an agreement with the Department for a higher payment rate under this section. Nursing facilities that apply shall be eligible to select an operating payment rate, for a RUG's level with a weight of 1.00, up to the rate calculated in section 23.150 without application of the phase-in under section 23.160. The rates for the other RUG's levels shall be computed as provided under section 23.150.

(b) For services delivered between October 1, 2011, and September 30, 2015, rates determined under this section shall be based on the most recent available cost report.

(c)The commissioner may, at any time, reduce the payments under this section based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this section and shall notify participating facilities of the reductions. The percentage would be calculated by dividing the amount over the upper payment limit by the total Medicaid payments for the participating facilities.

SECTION 20.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be

completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 15.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 15.010 as soon as possible.

SECTION 20.100 **Bed layaway and delicensure.**

A. For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under Sections 1.000 through 21.000 that places beds on layaway will, for purposes of application of the downsizing incentive in Section 16.040, item G, and calculation of the rental per diem, have the beds given the same effect as if the beds had been delicensed so long as they remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Section 16.110. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective under state law.

B. For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary in Section 22.000, a nursing facility reimbursed under Section 22.000 that places beds on layaway is, for so long as the beds remain on layaway, allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system in Section 22.000;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 16.110; and

(3) Establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

C. The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 22.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 22.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective.

D. If a nursing facility removes a bed from layaway status in accordance with state law, the Department will establish capacity days based on the number of licensed and certified

beds in the facility not on layaway and will reduce the nursing facility's property payment rate in accordance with item B.

E. For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under Section 22.000, a nursing facility reimbursed under that section, with delicensed beds after July 1, 2000, by giving notice of the delicensure to the Department of Health according to the notice requirements in state law, is allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 16.110; and

(3) Establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 22.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 22.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the delicensure of the beds becomes effective.

F. For nursing facilities reimbursed pursuant to Sections 1.000 to 21.000 or Section 22.000, any beds placed on layaway are not included in calculating facility occupancy as it pertains to leave days.

G. For nursing facilities reimbursed pursuant to Sections 1.000 to 21.000 or Section 22.000, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

H. A nursing facility receiving a rate adjustment as a result of this section must not increase nursing facility rates for private pay residents until it notifies the residents, or the persons responsible for payment of the increase, in writing 30 days before the increase takes effect. No notice is required if a rate increase reflects a necessary change in a resident's level of care.

I. A facility that does not utilize the space made available as a result of bed layaway or delicensure under this section to reduce the number of beds per room or provide more common space

for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this section reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Section 20.110. **Indian Health Service and Tribal 638 Facilities.** Effective July 6, 2011, per diem payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title I or title V of the Indian Self-Determination and Education Assistance Act, PL 93-638, shall be equal to the Medicaid outpatient per visit rate published annually by the Director of the Indian Health Service under the authority of sections 321(a) and 322(b) of the Public health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)) and the Indian Health Care Improvement Act (25 U.S.C 1601 *et seq.*))

SECTION 20.115 **Consolidation of nursing facilities effective September 1, 2011.**
A. The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities that includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under section 16.1374, item F. In the event the commissioners approve the request, the commissioner of human services shall calculate a property rate adjustment according to clauses (1) to (3):
(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 20.027;
(2) the construction project permitted in this clause shall not be eligible for a threshold project or a moratorium exception rate adjustment under section 22.061; and
(3) the property payment rate for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph.

B. For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):
(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;
(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;
(3) the estimated annual cost of elderly waiver recipients receiving support under group residential housing;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;
(5) the annual loss of license surcharge payments on closed beds;
(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 20.027; and
(7) the savings from not paying property payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 22.061.

C. For purposes of the calculation in paragraph A., clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

D. For purposes of net cost of savings to the state in paragraph B., the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

SECTION 20.120. **Method for determining budget-neutral nursing facility rates for relocated beds effective September 1, 2011.**

A. Nursing facility rates for bed relocations must be calculated by comparing the estimated medical assistance costs prior to and after the proposed bed relocation using the calculations in this subdivision. All payment rates are based on a 1.0 case mix level, with other case mix rates determined accordingly. Nursing facility beds on layaway status that are being moved must be included in the calculation for both the originating and receiving facility and treated as though they were in active status with the occupancy characteristics of the active beds of the originating facility.

B. Medical assistance costs of the beds in the originating nursing facilities must be calculated as follows:
(1) multiply each originating facility's total payment rate for a RUGS weight of 1.0 by the facility's percentage of medical assistance days on its most recent available cost report;
(2) take the products in clause (1) and multiply by each facility's average case mix score for medical assistance residents on its most recent available cost report;
(3) take the products in clause (2) and multiply by the number of beds being

relocated, times 365; and
(4) calculate the sum of the amounts determined in clause (3).

C. Medical assistance costs in the receiving facility, prior to the bed relocation, must be calculated as follows:
(1) multiply the facility's total payment rate for a RUGS weight of 1.0 by the medical assistance days on the most recent cost report; and
(2) multiply the product in clause (1) by the average case mix weight of medical assistance residents on the most recent cost report.

D. The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in paragraphs B and C.

E. The commissioner shall estimate the medical assistance costs after the bed relocation as follows:
(1) estimate the medical assistance days in the receiving facility after the bed relocation. The commissioner may use the current medical assistance portion, or if data does not exist, may use the statewide average, or may use the provider's estimate of the medical assistance utilization of the relocated beds;
(2) estimate the average case mix weight of medical assistance residents in the receiving facility after the bed relocation. The commissioner may use current average case mix weight or, if data does not exist, may use the statewide average, or may use the provider's estimate of the average case mix weight; and
(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a RUGS weight of 1.0 that is the highest rate of the facilities from which the relocated beds either originate or to which they are being relocated so long as that rate is associated with ten percent or more of the total number of beds to be in the receiving facility after the bed relocation.

F. If the amount determined in paragraph E is less than or equal to the amount determined in paragraph C, the commissioner shall allow a total payment rate equal to the amount used in paragraph E, clause (3).

G. If the amount determined in paragraph E is greater than the amount determined in paragraph D, the commissioner shall allow a rate with a RUGS weight of 1.0 that

when used in paragraph E, clause (3), results in the amount determined in paragraph D being equal to the amount determined in paragraph D.

H. If the commissioner relies upon provider estimates in paragraph E, clause (1) or (2), then annually, for three years after the rates determined in this subdivision take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and RUGS weight used in this subdivision and shall reduce the total payment rate for a RUGS weight of 1.0 if the factors used result in medical assistance costs exceeding the amount in paragraph D. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in paragraph E and the actual costs. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

SECTION 21.000 ANCILLARY SERVICES

SECTION 21.010 **Setting payment and monitoring use of therapy services.**
At the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services, or to the nursing facility outside of the operating cost per diem. Effective August 1, 2009, at the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made only to either the vendor of ancillary services or to the nursing facility outside of the operating cost per diem. The avoidance of double payments shall be made through audits and adjustments to the nursing facility's annual cost report. The Department will also determine if the materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, the Department may recover or disallow the payment for the services and may require prior authorization for therapy services or may impose administrative sanctions to limit the provider participation in the medical assistance program.

SECTION 21.020 **Certification that treatment is appropriate.** The therapist who provides or supervises the provision of therapy services must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The Department shall utilize a peer review program to make recommendations regarding the medical necessity of services provided.

SECTION 22.000 CONTRACTUAL ALTERNATIVE PAYMENT RATES AFTER AUGUST 1, 1995

SECTION 22.010 **Contractual alternative payment rate.** 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. A nursing facility selected to receive an alternative payment rate must enter into a contract with the state. Payment rates and procedures for facilities selected to receive an alternative payment rate are determined and governed by this section and by the terms of the contract. Different contract terms for different nursing facilities may be negotiated.

SECTION 22.020 **Requests for proposals.**

A. At least twice annually the Department will publish a request for proposals to provide nursing facility services according to this section. All proposals must be responded to in a timely manner.

B. Any proposal may be rejected if, in the judgment of the Department, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

SECTION 22.030 **Proposal requirements.**

A. In issuing the request for proposals, the Department may develop reasonable requirements which, in the judgment of the Department, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota.

B. The request for proposals may include, but need not be limited to, the following:

(1) A requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) Requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) Requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) A requirement to agree to participate in a project to develop data collection systems and outcome-based standards for managed care contracting for long-term care services;

(5) A requirement that contractors agree to maintain Medicare cost reports and to submit them to the Department upon request or at times specified by the Department;

(6) A requirement for demonstrated willingness and ability to develop and maintain data

collection and retrieval systems to be used in measuring outcomes; and

(7) A requirement to provide all information and assurances required by the terms and conditions of federal approval.

SECTION 22.040 **Selection process.**

A. The number of proposals that can be adequately supported with available state resources, as determined by the Department, may be accepted.

B. The Department may accept proposals from a single nursing facility or from a group of facilities through a managing entity.

C. The Department will seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

D. In addition to the information and assurances contained in the submitted proposals, the Department may consider the following in determining whether to accept or deny a proposal:

(1) The facility's history of compliance with federal and state laws and rules, except that a facility deemed by the Department to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposal. A facility's compliance history is not the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) Whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) The facility's financial history and solvency; and

(4) Other factors identified by the Department that it deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

E. If the Department rejects the proposal of a nursing facility, it will provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

SECTION 22.050 **Duration and termination of contracts.**

A. Contracts with nursing facilities may be executed beginning November 1, 1995.

B. All contracts entered into under this section are for a term not to exceed four years.

C. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable.

D. The contract will be renegotiated for additional terms of up to four years, unless either party provides written notice of termination. The provisions of the contract will be renegotiated at a minimum of every four years by the parties before the expiration date of the contract.

E. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

F. If a nursing facility fails to comply with the terms of a contract, the Department will provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance.

G. If the facility fails to come into compliance or to remain in compliance, the Department may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective as of the date the contract is terminated.

H. The contract must contain a provision governing the transition back to the cost-based reimbursement system established under Sections 1.000 to 21.000.

SECTION 22.060 **Alternate rates for nursing facilities.**

For nursing facilities that have their payment rates determined pursuant to this section rather than pursuant to Sections 1.000 to 21.000, a rate must be established under this section as follows:

A. The nursing facility must enter into a written contract with the Department;

B. A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the same payment rate as established for the facility under Sections 1.000 to 21.000;

C. A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an

inflation adjustment as provided in items D and E

D. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Minnesota Department of Finance's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year.

E. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

F. For the rate years beginning July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010 items C, D, and E apply only to the property related payment rate. For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under items C, D and E of this section shall be suspended. Beginning in 2005, adjustment to the property payment rate under Sections 1.000 through 21.000, and under this section, are effective on October 1, 2005. In determining the amount of the property related payment rate adjustment under items C, D and E, the Department must determine the proportion of the nursing facility's rates that are property related based on the facility's most recent cost report.

SECTION 22.061 **Construction project rate adjustments.**

A. Effective October 1, 2006, facilities paid under this section may receive a property rate adjustment for construction projects that exceed the threshold for additions and replacements described in section 16.1373, but are below the threshold described in section 16.1374, item F.

(1) For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are purchased within 24 months of the completion of the construction project, purchased after the completion date of any prior construction project, and are not purchased prior to July 14, 2005.

(2) Except as otherwise provided in this section, the definitions, rate calculation methods, and principles in Section 16.000 shall be used to calculate rate adjustments for allowable construction projects of facilities under this section and the moratorium exceptions process.

(3) Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date.

4) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment by submitting the request plus related supported documentation to the Department within 60 days after the project's completion date. Effective August 1, 2009, if a nursing facility gives notice more than 60 days after completion of a construction project, the rate adjustment is effective on the first of the month following the notice. If the notice is given within 60 days of completion, the rate adjustment is effective on the first of the month following the completion of the project.

(5) Capacity days shall be computed according to Section 16.110. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

B. The value of assets to be recognized for a total replacement project shall be computed as follows:

(1) Replacement-cost-new limits under Section 16.1374, and the number of beds allowed under Section 16.040, item G, shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(2) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under a moratorium exception, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under Section 16.1374, item G, or the actual allowable costs of the construction project.

(3) A current request that is not the result of a project under a moratorium exception cannot exceed the limit under Section 16.1374, item G.

(4) Applicable credits must be deducted from the cost of the construction project.

C. The value of assets to be recognized for all other projects shall be computed as follows:

(1) Replacement-cost-new limits under Section 16.1374, and the number of beds allowed under Section 16.040, item G shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(2) The value of a facility's assets to be compared to the amount in item (1) begins with the total appraised value from the last rate notice a facility received when its rates were

set under Sections 1.000 through 21.000. This value shall be indexed by the factor in Section 16.040 for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(3) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in subitem (1) minus the assets recognized in subitem (2) or the actual allowable costs of the construction project.

(4) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved as an exception to the state's moratorium, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under Section 16.1374, item G or the actual allowable costs of the construction project plus amendments approved by the Minnesota Department of Health. A current request that is not the result of a project under a moratorium exception cannot exceed the limit stated in section 16.1374, item G. Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

D. For construction projects approved under a moratorium exception, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in Section 16.1374, item G, or the replacement-cost-new limit less previously existing capital debt.

E. For construction projects that were not approved under a moratorium exception, allowable debt is limited to the lesser of the threshold in Section 16.1374, item G, or the applicable limit in items B or C, less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds. For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under Sections 1.000 through 21.000, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section. For a total replacement project as defined in section 16.1374, item H, the value of previously existing capital debt shall be zero.

F. In addition to the interest expense allowed from the application of item D, the amounts allowed under Section 16.1374, item B will be added to interest expense.

G. The equity portion of the construction project shall be computed as the allowable assets in item B or C, less the average debt in item D and F. The equity portion must be multiplied by 5.66 percent and the allowable interest expense in item D must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

H. For projects that are not a total replacement of a nursing facility, the amount in item G is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

I. For projects that are a total replacement of a nursing facility, the amount in item G becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under Section 16.1373, capital repairs and replacements under Section 16.1372, or refinancing incentives under Section 16.1376, shall be removed from the facility's rates.

J. No additional equipment allowance is allowed under Section 16.100, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

K. Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under Section 16.1374, item G, if they are purchased within 24 months of the completion of the future construction project.

L. In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in Section 22.060, item F.

M. Construction projects are eligible for an equity incentive under Section 16.1373. When computing the equity incentive for a construction project under this section, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under Section 22.060, item F. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under Section 16.1373, item C.

SECTION 22.065 **Facility rate increases beginning July 1, 1999.** For the rate year beginning July 1, 1999, a nursing facility's case mix rate is divided into the following components: compensation operating rate, non-compensation operating rate, property rate and other-components rate. The compensation and non-compensation operating rates are increased by the percentages in Section 11.049, item B, subitem (1), respectively. The property related payment rate is increased as described in Section 22.060, item F. The other-components rate is not increased from the June 30, 1999 rate.

A. A nursing facility in Becker county licensed for 102 beds on September 30, 1998 receives the following increases:

(1) $1.30 in its case mix class A payment rate;

(2) $1.33 in its case mix class B payment rate;

(3) $1.36 in its case mix class C payment rate;

(4) $1.39 in its case mix class D payment rate:

(5) $1.42 in its case mix class E and F payment rate;

(6) $1.45 in its case mix class G payment rate;

(7) $1.49 in its case mix class H payment rate;

(8) $1.51 in its case mix class I payment rate;

(9) $1.54 in its case mix class J payment rate; and

(10) $1.59 in its case mix class K payment rate;

B. A nursing facility in Chisago county licensed for 101 beds on September 30, 1998 receives an increase of $3.67 in each case mix payment rate:

C. A nursing facility in Canby, licensed for 75 beds will have its property-related per diem rate increased by $1.21. This increase will be recognized in the facility's contract payment rate under this section.

D. A nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to physically handicapped young adults has the payment rate computed according to this section increased by $14.83; and

E. A county-owned 130-bed nursing facility in Park Rapids has its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

SECTION 22.066 **Facility rate increases beginning July 1, 2000.** For the rate year beginning July 1, 2000, nursing facilities with an average operating rate as described in items A through F receive the

rate increases indicated. "Average operating rate" means the average of the eleven (A-K) case mix operating rates. The increases are added following the determination under Section 11.050 of the payment rate for the rate year beginning July 1, 2000, and will be included in the nursing facilities' total payment rates for the purposes of determining future rates under this attachment to the State plan.

A. Nursing facilities with an average operating rate of $110.769 receive an operating cost per diem increase of 5.9 percent, provided that the facilities delicense, decertify, or place on layaway status, if that status is otherwise permitted by law, 70 beds.

B. Nursing facilities with an average operating rate of $79.107 receive an increase of $1.54 in each case mix payment rate.

C. Nursing facilities with an average operating rate of $80.267 receive an increase in their case mix resident class A payment of $3.78, and an increase in their payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Section 13.030.

D. Nursing facilities with an average operating rate of $94.987 receive an increase of $2.03 in each case mix payment rate to be used for employee wage and benefit enhancements.

E. Nursing facilities with an average operating rate of $82.369 have their operating cost per diem increased by the following amounts:

(1) case mix class A, $1.16;

(2) case mix class B, $1.50;

(3) case mix class C, $1.89;

(4) case mix class D, $2.26;

(5) case mix class E, $2.63;

(6) case mix class F, $2.65;

(7) case mix class G, $2.96;

(8) case mix class H, $3.55;

(9) case mix class I, $3.76;

(10) case mix class J, $4.08; and

(11) case mix class K, $4.76.

F. Nursing facilities with an average operating rate of $95.974 that decertified 22 beds in calendar year 1999 have their property-related per diem payment rate increased by $1.59.

SECTION 22.067 **Facility rate increases 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, the rate is 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, the rate is 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 Section.

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 Breckenridge; 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

F. 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.

G. 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.

H. 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.

I. For the rate year beginning July 1, 2001, facilities that changed their bed licensure from board and care beds to nursing home beds must have the additional cost of surcharge included in their rate. The increase is added following the determination of the payment rate for the rate year beginning July 1, 2001, and is included in the facility's total payment rates for the purposes of determining future rates.

J. For the rate year beginning July 1, 2001, non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility receive a total increase of $10 in each case mix rate, as a result of increases provided under this item and item D. The increases under this item are added before the determination under item D,

of the payment rate for the July 1, 2001 rate year, and are included in the facility's total payment ate for purposes of determining future rates through June 30, 2004.

SECTION 22.068 **Facility rate increases beginning January 1, 2002.**

For the rate period from January 1, 2002 through June 30, 2002, facilities that went from non-profit to for-profit status in 2000 receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase will be added following the determination of the payment rate for the rate year beginning July 1, 2001, and will be included in a facility's total payment rates for the purposes of determining future rates.

SECTION 22.069 **Facility rate increases 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 items 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 22.067, 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 22.067, 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 22.067, 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 22.067, 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 Section 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 22.070 **Facility rate increases beginning June 1, 2003.**

Each facility paid pursuant to Section 22.000 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 22.071 **Facility rate changes 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.

SECTION 22.072 **Facility rate changes beginning January 1, 2004.** Effective January 1, 2004, the rates under Section 22.071 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 22.073 **Facility rate changes 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 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 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 22.074 **Changes to nursing facility reimbursement beginning October 1, 2005.**

A. For the rate period beginning October 1, 2005, each facility 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.

SECTION 22.075 **Changes to nursing facility reimbursement beginning October 1, 2006.**

A. For the rate year beginning October 1, 2006, each receives an adjustment equal to 1.2553

percent of the total operating payment rate.

B. Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff.

C. Seventy-five percent of the money received by the facility as a result of the adjustment must be used only for the Medicaid portion of wage, benefit, and staff increases implemented on or after the effective date of the rate increase and must not be used for increases implemented before that date.

D. A facility may apply for 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 and 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.

SECTION 22.076 **Quality add-on payment beginning October 1, 2006**

For rate years beginning October 1, 2006 facilities will be eligible for a payment increase based on performance, as follows.

A. By January 15, 2006, each facility paid pursuant to this Attachment will file a cost report.

(1) Reported costs will include only costs directly related to the operation of each facility. Therefore, costs that are separately paid by residents, Medical Assistance, or other payers are not to be included.

(2) Unless circumstances exist that are unusual and outside of the normal course of business operations, if a complete cost report is not submitted timely, the Department will reduce the payments to a nursing facility to 85% of amounts due until the information is filed. If a facility files the information within 90 days, it will receive the withheld payments. If a facility does not file the information within 90 days, it will not receive the withheld payments for any days after the 90th day.

(3) If the Department determines that a facility knowingly supplied inaccurate or false information, or failed to file an amendment to a cost report that resulted in or would result in an overpayment, the Department will immediately adjust the facility's payment rate and recover the entire overpayment. The Department may also terminate the Department's contract with the facility and prosecute under applicable state or federal law.

B. Effective October 1, 2006, the Department will calculate a quality score for each facility based on the factors below. For the October 1, 2006 rate year, the quality measures will include:

(1) staff turnover;

(2) staff retention;

(3) use of pool staff;

(4) quality indicators from the minimum data set; and

(5) survey deficiencies.

For each quality measure, the Department will assign a maximum number of points. For each facility, the Department will assign a number of points for each quality measure. The points will be totaled, resulting in the quality score.

When making revisions to the quality measures or method for calculating scores, the commissioner shall publish the methodology in the State Register at least 15 months prior to the start of the rate year for which the revised methodology is to be used for rate-setting purposes. The quality score used to determine payment rates shall be established for a rate year using data submitted in the statistical and cost report from
the associated reporting year, and using data from other sources related to a period beginning no more than six months prior to the associated reporting year.

Effective October 1, 2007, a nursing facility's quality score is determined on a 100 point scale. The total score is based on how well a nursing facility performs on six quality measures. The measures and corresponding weights are as follows: (1) quality indicators from the minimum data set, 35%; (2) resident quality of life surveys, 20%; (3) staff retention, 20%; (4) staff hours per resident day, 10%; (5) survey deficiencies, 10%; and (6) use of pool staff, 5%.

The standards for assigning scores are based on statistical assumptions for four of the measures (staff hours per resident day, staff retention, quality indicators and quality of life surveys). Thresholds for the other two measures, (use of pool staff and survey deficiencies) are based on expert opinion.

1. Nursing home MDS quality indicators (QIs) are derived from the Minimum Data Set (MDS) assessment instrument. The QIs measure quality mainly in clinical areas such as physical functioning, skin care, and pain. The 23 indicators are risk-adjusted, scored, and summed to form a composite facility QI score which can range from 0-40. Thresholds used for each

quality indicator are based on data from January 1, 2006 through December 31, 2006. The best 20% of the facilities for each QI in the state receive full points assigned to that QI, the poorest 15% of the facilities in the state for that QI receive no points. Points are distributed on a straight line relationship between those two thresholds.

2. Quality of life and resident satisfaction measures (QoL/RS) based on an annual in-person survey of a representative sample of residents (approximately 14,000). Domains measured in the survey are satisfaction with care, mood, comfort, environmental adaptations, privacy, dignity, meaningful activity, food enjoyment, autonomy, individuality, security, and relationships. Proportions of positive responses in each domain are summed to form a total QoL/RS score which is risk-adjusted. The thresholds for maximum and minimum points are set at the 80th and 10th percentile of the risk-adjusted 2006 scores for each domain.

3. Staff retention rates calculated according to the number of direct care employees on October 1 of the base year that were still employed on September 30 the following year, divided by number of direct care employees on October 1 of the base year. Facilities with a retention rate of 80% or higher earn maximum points. The minimum threshold fluctuates annually based on the 10th percentile of the data for the current reporting year.

4. Direct care staff hours per resident day (HPRD) is a composite measure weighted by the relative costs (wages and benefits) for direct staff types, e.g., RN, LPN, nursing assistant, etc., and the average RUG-III case-mix index score for each facility. The HPRD points are assigned by peer groups – Hospital-affiliated, standard, and board and care facilities.. Thresholds for minimum and maximum points are based on the 10th and 80th percentiles in the data from 2005.

5. Minnesota Department of Health (MDH) Survey findings are scored with an algorithm developed by the Minnesota Department of Health. Facilities are scored from 0-10 according to findings of their most recent or prior MDH survey, confirmed complaints, and listing as a Special Focus provider. The facility score takes into account number of deficiencies, particularly those indicting actual harm, substandard quality of care, or immediate jeopardy.

6. Use of temporary/pool staff is the annual number of temporary or pool staff hours divided by total direct care staff hours. All facilities who do not use pool receive maximum points, and those that do use pool lose points on a straight line basis until they reach the threshold of twice the state average of pool use among facilities that use pool, where they will receive no points

C. Effective October 1, 2006, the Department must set a quality add-on for each facility, which will be a variable amount based on each facility's quality score. For the October 1, 2006 rate year, the maximum quality add-on percent will be 2.4%. The quality add-on will be determined as follows:

(1) for each facility, determine the operating payment rate.

(2) for each facility, determine a ratio of the quality score determined in item B above, less 40 and then divided by 60. If this value is less than zero, zero is the value.

(3) for each facility, the quality add-on equals the value determined in clause (1) times the value determined in clause (2) times the maximum quality add-on percent.

D. Effective October 1, 2007, the quality add-on is a variable amount based on each facility's quality score. For the rate year, the maximum quality add-on is .3 percent of the operating payment rate in effect on September 30, 2007. The quality add-on shall be determined as follows:

a. For each facility, determine the operating payment rate in effect on September 30, 2007.
b. For each facility, determine a ratio of the quality score of the facility determined in item B above, less 40, then divided by 60. If this value is less than zero, zero is the value.
c. For each facility, the quality add-on equals the value determined in paragraph a, multiplied by the value determined in paragraph b, multiplied by .3 percent.

SECTION 22.0761 **Performance-incentive payments beginning July 1, 2007.**

A. Beginning July 1, 2007, nursing facilities may contract to earn negotiated performance-incentive Medicaid payments up to five percent above the facilities' operating payment rates for achieving contracted improvements in their quality of services. The Commissioner will accept qualified proposals from facilities submitted in response to an annual request for proposals that are designed to improve outcomes or achieve efficiencies through diverting or discharging residents to the community, adopting new technology to improve quality or efficiency, improve quality as measured by the Nursing Home Report Card or reduce acute care costs. Nursing facilities with existing contracts for the maximum 5% performance incentive payments for rate year October 1, 2009 are not eligible to apply. Criteria that will be used by the selection committee in reviewing the proposals include: the importance of the proposal; whether it is evidence-based; whether its goals are objective, measurable, reliable and prospective; whether it is innovative and feasible; whether it has broad-based applicability; and whether any collaborative plan is clear.

The Department will enter into negotiations with those providers recommended by the selection committee. The total computable amount for state fiscal year 2009 is $6,714,000 plus federal financial participation. The total computable amount for state fiscal year 2010 and subsequent years is $6,042,600 plus federal financial participation. The incentive payments are time-limited rate adjustments paid for one to three years depending upon the project as approved for payment

by the Commissioner. Payments are made in the usual manner in the monthly remittance advice as part of the daily per diem for Medicaid eligible nursing home residents.

B. Specified outcomes and related criteria shall consider:
(1) successful diversion or discharge of residents to the community;
(2) adoption of new technology to improve quality or efficiency;
(3) improved quality as measured by the Nursing Home Report Card;
(4) reduced acute care costs; and
(5) any additional outcomes proposed by a facility that the Commissioner of Human Services finds desirable.

SECTION 22.0762 **Changes to nursing facility reimbursement beginning October 1, 2007.**

A. Effective October 1, 2007, a nursing facility in Otter Tail County that was licensed for 57 beds as of December 31, 2004, shall receive an increase to the 60th percentile of the operating rates of all other Otter Tail County nursing facilities.

B. Effective October 1, 2007, a nursing facility in Martin County licensed for 93 beds as of January 1, 2006, shall receive an increase in the operating rate of $5 per resident day for all case mix classes.

C. For the rate year beginning October 1, 2007, each facility receives an operating payment rate adjustment equal to 1.87 percent of the operating payment rate in effect on September 30, 2007.

(1) Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of the compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustment, except:

(a) the administrator;
(b) central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or
(c) persons paid by the facility under a management contract.

(2) Two-thirds of the money available for compensation-related costs must be used for the Medicaid portion of wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustment except those listed in clause 1(a) through (c).

(3) The wage adjustment that employees receive under paragraph (2) must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employes shall be allowed only for meeting the requirements in clause 1. This paragraph shall not apply to employees covered by a collective bargaining agreement.

(4) Compensation-related costs shall include all costs for:

(a) wages and salaries;
(b) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
(d) other benefits provided, subject to the approval of the commissioner.

(5) The portion of the rate adjustment under paragraph C that is not subject to the requirements in clauses 1 and 2 shall be provided to facilities effective October 1, 2007.

(6) Facilities may apply for the portion of the rate adjustment under paragraph C that is subject to the requirements in clauses 1 and 2. The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this clause under circumstances that are unusual and outside of the normal course of business operations. The application must contain:

(a) an estimate of the amounts of money that must be used as specified in clauses (1) and (2);

(b) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in paragraph (a);

(c) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (a), or posting a copy of the approved application, excluding the information required in clause (a), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(d) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(7) The commissioner shall ensure that cost increases in distribution plans under paragraph (6), clause (b), that may be included in approved applications, comply with the following requirements:

(a) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the nursing facility's payroll period that includes October 1, 2007, shall be allowed if they were not used in the prior year's application;

(b) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to the following:
(i) determine the facility's employee retention rate;
(ii) sum the median statewide average employee retention rate and one-half of the standard deviation of the statewide average employee retention rate;
(iii) if the amount in (i) is greater than the amount in (ii), the facility will be allowed to use in its distribution plan a percentage of anniversary increases equal the amount in (i) multiplied by the difference between the amount in (I) and (ii).

(c) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability

insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2007, and prior to April 1, 2008; and

(d) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after enactment of this subdivision. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(8) The commissioner shall review applications received under paragraph (6) and shall provide the portion of the rate adjustment under clauses (1) and (2) if the requirements of this item have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph C, if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

D. Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ended on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

SECTION 22.0763 **Nursing facility rate increase beginning October 1, 2008.**

For the rate year beginning October 1, 2008, each facility receives an operating payment rate adjustment equal to 1.00 percent of the operating payment rate determined by the blending in Section 23.160.

(1) Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of the compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustment, except:

(a) the administrator;
(b) central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or
(c) persons paid by the facility under a management contract.

(2) Two-thirds of the money available for compensation-related costs must be used for the Medicaid portion of wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustment except those listed in clause (1)(a) through (c).

(3) The wage adjustment that employees receive under paragraph (2) must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in clause 1. This paragraph shall not apply to employees covered by a collective bargaining agreement.

(4) Compensation-related costs shall include all costs for:

(a) wages and salaries;
(b) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
(d) other benefits provided, subject to the approval of the commissioner.

(5) The portion of the rate adjustment under paragraph A that is not subject to the requirements in clauses 1 and 2 shall be provided to facilities effective October 1, 2008.

(6) Facilities may apply for the portion of the rate adjustment under paragraph A that is

subject to the requirements in clauses 1 and 2. The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this clause under circumstances that are unusual and outside of the normal course of business operations. The application must contain:

(a) an estimate of the amounts of money that must be used as specified in clauses (1) and (2);

(b) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in paragraph (a);

(c) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (a), or posting a copy of the approved application, excluding the information required in clause (a), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(d) instructions for employees who believe they have not received the compensation-related or wage increases specified in paragraph (b), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(7) The commissioner shall ensure that cost increases in distribution plans under paragraph (6), clause (b), that may be included in approved applications, comply with the following requirements:

(a) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2007, and prior to the first day of the nursing facility's payroll period that includes October 1, 2008, shall be allowed if they were not used in the prior year's application;

(b) a portion of the costs resulting from tenure-related wage or salary

increases may be considered to be allowable wage increases, according to the following:

(i) determine the facility's employee retention rate;

(ii) sum the median statewide average employee retention rate and one-half of the standard deviation of the statewide average employee retention rate;

(iii) if the amount in (i) is greater than the amount in (ii), the facility will be allowed to use in its distribution plan a percentage of anniversary increases equal to the amount in (i) multiplied by the difference between the amount in (i) and (ii).

(c) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2008, and prior to April 1, 2009; and

(d) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after enactment of this subdivision. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(8) The commissioner shall review applications received under paragraph (6) and shall provide the portion of the rate adjustment under clauses (1) and (2) if the requirements of this item have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph A, if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

22.0764. **Temporary nursing facility rate adjustment beginning October 1, 2008**

For the rate year beginning October 1, 2008, each facility receives a temporary operating payment rate adjustment equal to 1.00 percent of the operating payment rate determined by the blending in Section 23.160. This rate adjustment shall be removed from the facility's operating payment rate for the rate year beginning October 1, 2009.

Seventy-five percent of the money resulting from the rate adjustment must be used to provide the

Medicaid portion of quarterly bonus payments and to pay for associated employer costs and other benefits as specified in Section 22.0763 for all employees directly employed by the facility on December 31, 2008, March 31, 2009, June 30, 2009, and September 30, 2009, except:

i. the administrator;
ii. central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or
iii. persons paid by the facility under a management contract.

Two-thirds of the money available as described above in this section must be used for the Medicaid portion of an equal hourly percentage wage bonus wage increase for all eligible employees.

Facilities may apply for the portion of the rate adjustment described above in this section which shall be acted on by the commissioner as described in section 22.0763, item (6). The portion of the rate adjustment that is not part of the seventy-five percent described above in this section shall be provided to facilities effective October 1, 2008.

SECTION 22.0765 **Payment for post-PERA pension benefit costs**

Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percent of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 1.000 to 23.000 shall be applied to the allowable amount. The adjusted allowable amount shall be added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate.

SECTION 22.0766 **Special diet adjustment**
For rate years beginning on or after August 1, 2010, in calculating a facility's operating cost per diem for the purposes of comparing to an array, a median, or other statistical measure of facility payment rates to be used to determine future rate adjustments, 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 22.077 **Contract payment rates; appeals.** If a provider appeal is pending concerning the

cost-based payment rates that are the basis for the calculation of the payment rate under the contractual alternative payment methodology, the Department and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Section 22.078 **Rate adjustment for sprinkler federal compliance.** Beginning October 1, 2007, and ending September 30, 2008, a rate adjustment is available for facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems. Facilities will receive reimbursement for the Medicaid portion of the costs associated with compliance if all of the following conditions are met:

A. the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;
B. the costs were not otherwise reimbursed ; and
C. the total allowable costs reported are less than the minimum threshold established under sections 16.1372 and 16.1373.

Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose according to the Department of Human Services' established credit balance process. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

SECTION 22.080 **Exemptions.** To the extent permitted by federal law:

A. Nursing facilities that are Medicare certified and filing a Medicare cost report and have entered into a contract under this section are not required to file a cost report as described in Section 2.000 for any year after the base year that is the basis for the calculation of the contract

payment rate for the first rate year of the alternative payment contract. Nursing facilities that are not Medicare certified and are not filing a Medicare cost report must file a cost report as described in Section 2.000.

B. A facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract, and all subsequent rate years affected by changes to that first rate year payment rate.

C. A facility that is under contract with the state under this section is not subject to the state's moratorium law on licensure or certification of new nursing home beds, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph.

D. As a condition of entering into a contract under Section 22.000, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under the State plan or to construction undertaken under this section that otherwise would not be authorized under the moratorium exception process.

E. Nothing in this section prevents a nursing facility participating in the contractual alternative payment rate methodology described in this section from seeking approval of an exception to the state's nursing home moratorium law through the process established in that law. The projected costs of the moratorium exception project are not required to exceed the cost threshold, which is $1,000,000 plus inflation added annually for projects approved after July 1, 2001.

(1) If a moratorium exception application is approved, the nursing facility's payment rate for property shall be adjusted to reflect the cost of the approved project.

(2) If a nursing facility ~~from~~ receives legislative approval of an exception to the moratorium, the facility's rate must be adjusted to reflect the cost of the project.

F. Notwithstanding the state's law governing the level of nursing home Medicare certification, and pursuant to any terms and conditions contained in the facility's contract, a nursing facility contracting with the state under this section is in compliance with state laws if the nursing facility is Medicare certified.

G. A nursing facility under contract is allowed to change therapy arrangements from an unrelated vendor (i.e., a therapist not working for the nursing facility) to a related vendor during the term of the contract.

SECTION 22.090 **Consumer protection.**

A. As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under state law.

B. The nursing facility may also be required to establish expedited grievance procedures to resolve complaints made by short-stay residents.

C. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

SECTION 22.100 **Contracts are voluntary.**

A. Election by a nursing facility of the contractual alternative payment rate is voluntary.

B. The terms and procedures governing the alternative payment rates are determined under Section 22.000 and through negotiations between the Department and nursing facilities that have submitted a letter of intent to elect the alternative payment rate.

C. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts, the Department is exempt from state rulemaking requirements.

SECTION 22.110 **Federal requirements.** The Department will implement the contractual alternative payment methodology subject to any required federal approvals, and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement, the federal requirement supersedes the inconsistent provision. The Department will seek federal approval and request waivers as necessary to implement this section.

SECTION 22.120 **Salary adjustments.** Effective July 1, 1998, made available the appropriate salary adjustment per diem calculated in Section 11.070 to the total operating cost payment rate of each nursing facility subject to payment under this section. This salary adjustment per diem became part of the operating payment rate in effect on June 30, 2001.

SECTION 22.130 **Separate billings for therapy services.** Nursing facilities must limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to the inflated amount from the facility's base year cost report. Nursing facilities that are located in a county participating in the state's §1115 prepaid medical assistance waiver program are exempt from this maximum therapy rent revenue requirement.

SECTION 22.140 **Payment for preadmission screening fees.** The estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate.

SECTION 22.150 **Noncompliance with baseline statistical and cost information.** If a nursing facility fails to comply with the baseline statistical and cost information requirements of state law that require such information by August 31, 2004, the Department shall reduce the nursing facility's payments to 85% of the amount they would otherwise have received. The reinstatement of withheld payments is retroactive for no more than 90 days.

SECTION 23.000 Rebasing of nursing facility operating payment rates.

SECTION 23.010 **Rebasing of nursing facility operating payment rates.**
The commissioner shall rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

SECTION 23.020 **Phase-in of rebasing beginning October 1, 2008.**
The new operating payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

SECTION 23.030 **Rebased property payment rates beginning October 1, 2014**
Effective October 1, 2014, property rates shall be rebased in accordance with section 16.000. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under Section 22.000. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Section 16.000, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

SECTION 23.040 **Rebased operating payment rates beginning October 1, 2016**
Operating payment rates shall be rebased on October 1, 2016, and every two years after that date. Each cost reporting year shall begin on October 1 and end on the following September 30. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

SECTION 23.050 **Definitions.**

Active beds. "Active beds" means licensed beds that are not currently in layaway status.

Activities costs. "Activities costs" means the costs for the salaries and wages of the supervisor and other activities workers, associated fringe benefits and payroll taxes, supplies, services, and consultants.

Administrative costs. "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in direct care costs, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Allowed costs. "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for accuracy; reasonableness, in accordance with the requirements set forth in Title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this section and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

Centers for Medicare & Medicaid Services. "Centers for Medicare & Medicaid Services or CMS" means the federal agency, in the United States Department of Health and Human Services that administers Medicaid.

Commissioner. "Commissioner" means the commissioner of human services unless specified otherwise.

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

Dietary costs. "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room,

and associated fringe benefits and payroll taxes. Dietary costs also include the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Direct care costs. "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training on resident care topics, and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems. Effective August 1, 2009, direct care costs also means wages of employees conducting training in resident care topics, costs of materials used for resident care training and training course outside of the facility attended by direct care staff on resident care topics.

External fixed costs. "External fixed costs" means costs related to the nursing home surcharge; Minnesota Health Department licensure fees; long-term care consultation fees; family advisory council fees; scholarships; planned closure rate adjustments; or single bed room incentives; property taxes and property insurance; and PERA.

Facility average case mix index. "Facility average case mix index" or "CMI" means a numerical value score that describes the relative resource use for all residents within the groups under the resource utilization group (RUG-III) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility. The RUG's weights used in this section shall be as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000.

Facility type groups. Facilities shall be classified into two groups, called "facility type groups," which shall consist of:
(1) C&NC/R80: facilities that are hospital-attached, or are licensed as described in Section 20.030; and
(2) freestanding: all other facilities.

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

Fringe benefit costs. "Fringe benefit costs" means the costs for group life, health, dental, workers' compensation, and other employee insurances and pension, profit-sharing, and retirement plans for which the employer pays all or a portion of the costs.

Generally accepted accounting principles. "Generally Accepted Accounting Principles" means the body of pronouncements adopted by the American Institute of Certified Public Accountants regarding proper accounting procedures, guidelines, and rules.

Hospital-attached nursing facility status. (a) "Hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. 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.

Housekeeping costs. "Housekeeping costs" means the costs for the salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning employees and associated fringe benefits and payroll taxes. It also includes the cost of housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and contract services.

Laundry costs. "Laundry costs" means the costs for the salaries and wages of the laundry supervisor and other laundry employees, associated fringe benefits, and payroll taxes. It also includes the costs of linen and bedding, the laundering of resident clothing, laundry supplies, and contract services.

Licensee. "Licensee" means the individual or organization listed on the form issued by the Minnesota Department of Health.

Maintenance and plant operations costs. "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes direct costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

Normalized direct care costs per day. "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Nursing facility. "Nursing facility" means a facility with a medical assistance provider agreement that is licensed by the Department of Health as a nursing home or as a boarding care home which meets federal certification requirements for a nursing facility.

Other direct care costs. "Other direct care costs" means the costs for the salaries and wages and associated fringe benefits and payroll taxes of mental health workers, religious personnel, and other direct care employees not specified in the definition of direct care costs.

Payroll taxes. "Payroll taxes" means the costs for the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Peer groups. Facilities shall be classified into three groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue,

Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) group three: facilities in all other counties.

Prior system operating cost payment rate. "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota rules and Minnesota statutes, not including planned closure rate adjustments as described in Section 20.027, or single bed room incentives described in Section 11.056B and Section 22.073B,

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

Rate year. "Rate year" means the 12-month period beginning on October 1 following the second most recent reporting year.

Raw food costs. "Raw food costs" means the cost of food provided to nursing facility residents. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Related organization. "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subdivision, paragraphs (a) to (d) apply.

(a) "Affiliate" means 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) "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(c) "Close relative of an affiliate of a nursing facility" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(d) "Control" including the terms "controlling," "controlled by," and "under common control with" means 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.

Reporting period. "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report.

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. The day of admission is considered a resident day, regardless of the time of admission. The day of discharge is not considered a resident day, regardless of the time of discharge.

Salaries and wages. "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued vested vacation and accrued vested sick leave pay. Salaries and wages must be paid within 30 days of the end of the reporting period in order to be allowable costs of the reporting period.

Social services costs. "Social services costs" means the costs for the salaries and wages of the supervisor and other social work employees, associated fringe benefits and payroll taxes, supplies, services, and consultants. This category includes the cost of those employees who manage and process admission to the nursing facility.

Stakeholders. "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Standardized days. "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category.

Statistical and cost report. "Statistical and cost report" means the forms supplied by the commissioner for annual reporting of nursing facility expenses and statistics, including instructions and definitions of items in the report.

Therapy costs. "Therapy costs" means any costs related to medical assistance therapy services provided to residents that are not billed separately from the daily operating rate.

Section 23.060. **Reporting of statistical and cost information.** (a) All nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the

commissioner. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to Section 3.040. The commissioner may grant to facilities one extension of up to 15 days for the filing of this report if the extension is requested by December 15 and the commissioner determines that the extension will not prevent the commissioner from establishing rates in a timely manner required by law. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to section 23.060. The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed ten days to complete the report prior to any payment reduction. If circumstances exist that are unusual and ouside of the normal course of business operations, the commissioner may delay the payment withhold at the sole discretion of the the commissioner. An example of an exceptional circumstance would be the illness of several employees involved in cost report preparation.

(b) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Section 23.070. **Audit authority.** (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this section. Retroactive adjustments shall be made as a result of desk or field audit findings if the cumulative impact of the finding would result in a rate adjustment of at least 0.15 percent of the statewide weighted average operating payment rate. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

(b) Field audits may cover the four most recent annual statistical and cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's statistical and cost report. All transactions, invoices, or other documentation that support or relate to the statistics and costs claimed on the annual statistical and cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the statistical and cost report within the time period specified by the commissioner, the commissioner shall calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided.

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

(d) The commissioner shall extend the period for retention of records under section 23.050 for purposes of performing field audits as necessary to enforce Minnesota Statutes, 256B.48 with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Section 23.080. **Calculation of operating per diems.**
The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs,

other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.

Section 23.090. **Determination of total care-related per diem.** The total care-related per diem for each facility shall be the sum of the direct care per diem and the other care-related per diem.

Section 23.100. **Determination of total care-related limit.** (a) The limit on the total care-related per diem shall be determined for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

(b) Beginning with rates determined for October 1, 2016, the total care-related limit shall be a variable amount based on each facility's quality score, as determined under section 22.076:

(1) for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage;

(2) if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group;

(3) if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and

(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).

Section 23.110. **Determination of proximity adjustments.**
A. For a nursing facility located in close proximity to another nursing facility of the same facility type group but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

B. Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either section 23.100 or 23.120, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in section 23.050. The nearest facility is determined based on the mileage of the most direct driving route.

Section 23.120. **Determination of other operating limit.** The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Section 23.130. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with another operating per diem that exceeds the limit in section 23.110 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Section 23.140. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs. The state will pay the Medicaid portion of the following calculated rate:

(a) For a facility licensed as a nursing home, the portion related to Minnesota Statutes, §256.9657, shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to Minnesota Statutes, §256.9657, shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the Minnesota Department of Health licensure fee shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under Section 20.060.

(d) The portion related to long-term care consultation shall be determined according to Section 17.010.

(e) The portion related to development and education of resident and family advisory councils shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under Section 20.027. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under Section 11.056B and Section 22.073B. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Section 23.150. **Determination of total payment rates.** In rate years when rates are rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate determined under section 22.060. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level using the weights included in the definition of "facility average case mix index" in section 23.040.

23.160. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1,

2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 22.000. For purposes of this subdivision, the rate to be used that is determined under section 22.000 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 22.0761. From October 1, 2008 through September 30, 2013, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 22.000. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 22.000. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 22.000. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using the rate with a RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) that is greater than 3.2 percent when compared to its operating payment rate on September 30, 2008, computed using the rate with a RUG's weight of 1.00, shall receive a rate adjustment of 3.2 percent.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) that is greater than one percent and less than 3.2 percent when compared to its operating payment rate on September 30, 2008, computed using the rate with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) Facilities that had rates limited by 3.2 percent under clause (2) for the rate year beginning on October 1, 2008, will have rates adjusted for the years beginning on October 1, 2009, through October 1, 2015, according to this clause. After computing the rates as described in paragraph (a), the difference between the rate computed under paragraph (a) for the October 1, 2008, rate year and the rate allowed after applying the 3.2 percent limit in clause (2) for the October 1, 2008, rate year shall be determined. This difference will be deducted from the rates computed under paragraph (a) for the

rate years beginning on October 1, 2009, through October 1, 2015.

(c) A portion of the funds received under this section that are in excess of operating payment rates that a facility would have received under section 22.000, as determined in accordance with clauses (1) to (4), shall be subject to the requirements in section 22.0762 item C, paragraphs (1) to (8).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this section that shall be subject to the requirements in section 22.0762 item C, paragraphs (1) to (8) shall equal the amount determined in clause (1) times the amount determined in clause (3).

Section 23.170. **Hold harmless.** For the rate years beginning October 1, 2008, to October 1, 2016, no nursing facility shall receive an operating cost payment rate less than its operating cost payment rate under section 22.000. For rate years beginning between October 1, 2009, and October 1, 2015, no nursing facility shall receive an operating payment rate less than its operating payment rate in effect on September 30, 2009. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Section 23.180. **Appeals.** Nursing facilities may appeal, as described under Minnesota Statutes, §256B.50, the determination of a payment rate established under this section.

Section 23.190. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under sections 23.010 through section 23.030; (2) quality-based rate limits under section 23.090; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under section 23.130, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under section 23.030, and the removal of planned closure rate adjustments and single-bed room incentives from external fixed costs under section 23.140 shall not go into effect until 82 percent

of the operating payment rate from this section is phased in as described in section 23.160.

SECTION 23.200 **Rate increase for low-rate facilities.**
Effective October 1, 2011, operating payment rates of all nursing facilities that are reimbursed under Section 22 or 23 shall be increased for a resource utilization group rate with a weight of 1.00 by up to 2.45 percent of the September 30, 2011 operating rate, but not to exceed for the same resource utilization group weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's operating payment rate on the preceding September 30.

SECTION 23.210 **Repeal of rebased operating payment rates.**
Notwithstanding sections 23.150 and 23.160, effective October 1, 2011, no further steps toward phase-in of rebased operating payment rates shall be taken.

OS Notification

State/Title/Plan Number: Minnesota 12-011

Type of Action: SPA Approval

Required Date for State Notification: June 11, 2012

Fiscal Impact: FY 2012 $0
FY 2013 $0

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after January 1, 2012, this amendment revises methods and standards for determining payment rates for services provided by nursing facilities (NF). Specifically, with this amendment the State will use the MDS version 3.0 assessment instrument and transition its case mix system to the 48 group RUG-IV model when determining case mix classifications for NF residents for rate setting purposes. Additionally, the State is proposing to add penalty and default groups for a total of 50 RUG levels. The State met public process requirements. Funding the non-Federal share of these payments comes from appropriations. There are no issues with the UPL.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact: Todd McMillion (608) 441-5344
National Institutional Reimbursement Team