CHAPTER 9510
DEPARTMENT OF HUMAN SERVICES
RATES FOR HEALTH CARE FACILITIES

RATES FOR NURSING HOME PROVIDERS

9510.0010 STATUTORY AUTHORITY.

Parts 9510.0010 to 9510.0480 are enacted pursuant to the statutory authority vested in the commissioner of human services pursuant to Minnesota Statutes, section 256B.27 to require reports, information, and audits, and pursuant to Minnesota Statutes, section 256B.04, subdivision 2, to promulgate rules for carrying out and enforcing the provisions of Minnesota Statutes, chapter 256B. Parts 9510.0010 to 9510.0480 are further promulgated pursuant to the procedures set out in Minnesota Statutes, sections 14.05 to 14.36, of the Minnesota Administrative Procedure Act.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1984 c 654 art 5 s 58*

9510.0020 PURPOSE.

The procedures embodied herein define a system for the determination of per diem welfare rate for all nursing homes participating in the medical assistance program and board and care licensed facilities participating in the Minnesota supplemental aid program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these rules if nursing home patients account for 50 percent or more of the facility population.

Procedures have been defined to satisfy the state plan for medical assistance and HEW Medical Services Administration Program Regulation Guide 19, which prescribes reasonable charges/cost–related rate–setting methods. The rate–setting procedures have also been defined to comply with the state statute that requires that cost differences between individual providers be recognized (Minnesota Statutes, section 256B.04, subdivision 2) while at the same time establishing cost limitations to satisfy federal requirements that the welfare rates be consistent with efficiency, economy, and quality or care.

The welfare rate–setting procedures included herein also recognize required level and quality of care as defined by all governmental entities including, but not limited to federal, state, and local entities, establish effective accountability over the disbursement of medical assistance appropriations, and provide for a regular review mechanism for rate changes.

While the rate–setting procedures are intended to compensate the provider for the reasonable cost incurred by prudent management, including a return of capital through depreciation, they are not intended to provide funds for financing working capital needs or purchase of facilities. It is not intended that the rules provide for reimbursement of actual cost through retroactive settlement.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0030 METHOD OF CALCULATING PER DIEM RATE.

Subpart 1. **Historical rate.** The method of calculating the nursing home provider per diem rate for skilled, ICF I, and ICF II facilities will be to determine reasonable costs for the most current fiscal year and divide by adjusted patient days according to reasonable cost provisions of parts 9510.0230 to 9510.0450 and cost–reporting rules contained in parts 9510.0150 to 9510.0220.

Subp. 2. **Incentive factors.** Incentive factors include the following:

A. In no case will the historical rate so determined under subpart 1 be less than the historical rate calculated for the previous year minus one–half of the difference. This provision shall not apply for rates for newly established providers under part 9510.0070, rates set

by applying exceptions provided by part 9510.0440, subpart 4, and flat rates established under part 9510.0110. For multilevel providers this provision will be applied to the facilities average historical rates.

B. Per diem rates for nonproprietary facilities may include an efficiency allowance. If the facility's allowable historical cost per patient per day for the most recently completed fiscal year is less than the allowable welfare rate exclusive of part 9510.0130, subparts 1 and 2 and as adjusted for the lack of implementation of known cost changes, an efficiency allowance will be granted equal to the difference between the allowable historical cost and the allowable welfare rate subject to a maximum efficiency allowance of 60 cents per patient per day. For each year after the year in which the nonproprietary facility was originally purchased and there is no transfer of ownership of the facility, the efficiency allowance maximum will be increased one cent per patient per day subject to a maximum of an additional 25 cents per patient per day after 25 years. If a nonproprietary facility is operated on a lease basis, there shall not be recognized as an allowable cost for the operator any rental fees in excess of the total amount allowed for depreciation, interest, and pursuant to item B, provided, however, that such a rental fee may be recognized in entirety for the period that it was incurred under a lease entered into before April 13, 1976, and prior to the subsequent renewal of said lease. This provision of the rule will be effective for rates paid nonproprietary facilities on January 1, 1978, and subsequent until such time as it is disapproved by HEW.

Subp. 3. **Allowance for known cost changes.** Future cost increases or decreases that are in accordance with the reasonable cost principles of parts 9510.0230 to 9510.0300 known as of the report filing date, must be added to or deducted from the historical rate determined according to subparts 1 and 2. Such adjustment will be restricted to the elements defined in items A to H and shall be the annualized cost effect of such cost changes exclusive of any portion of the cost change included in the historical rate.

A. Salary and wage changes to occur during the effective period of the welfare rate:

(1) future changes according to labor contracts, board resolutions, written policies, or minimum wage laws; and

(2) changes that are in effect as of the end of the fiscal period covered by the historical cost portion of the welfare per diem rate.

B. Changes in facilities or equipment.

C. The annualized cost effect of complying with federal, state, or local laws and regulations and Department of Human Services announced policies on care or facilities.

D. All taxes except for income taxes.

E. Interest.

F. Depreciation.

G. Utilities and insurance.

H. Rental payments pursuant to a written lease.

I. Raw food cost increase computed annually by multiplying the average food cost per day by the percentage change in the consumer price index for raw food costs in Minneapolis–Saint Paul as published by the Bureau of Labor Statistics for the period October through September. The initial average food cost is $1.82 per day and the initial increase is 22 cents per day. Subsequent annual cost changes will be made on a calendar basis.

J. Unidentified cost increases equal to changes in the annual percentage increase in the consumer price index in Minneapolis–Saint Paul as published by the Bureau of Labor Statistics, using the October indices (new series index 1975 equals 100) as applied to the historical cost portion of the facilities previous year's cost less those costs relating to areas where the facility is seeking specific allowances for known cost changes. In no case may the increase be applied against the historical cost of salaries, changes in facilities or equipment, property taxes, interest, depreciation, rental payments, or food costs.

Cost changes determined under this provision must be based upon facts and commitments in existence as of the original filing date of the report part 9510.0150, subpart 5, item A. If the provider cannot substantiate that such facts and commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to part 9510.0060. If known

cost changes calculated under items A to H do not in fact occur, the welfare rate will similarly be subject to adjustment under part 9510.0060. If actual cost increases exceed the known cost changes determined under items A to I, no adjustment in welfare rate will be made.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1984 c 654 art 5 s 58*

9510.0040 EFFECTIVE DATE OF NEW RATE.

A new per diem rate determined by the department will be effective the first day of the month following the provider's normal fiscal year–end except in instances in which penalty provisions of part 9510.0150, subpart 6 are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0050 RATE NOTIFICATIONS.

A temporary rate notification consisting of the previous year's allowed historical cost per patient day plus 80 percent of the indicated allowed known cost changes per patient day will be issued and paid on receipt of the report. The temporary rate shall be limited by all maximums contained in parts 9510.0010 to 9510.0470. Individual as well as overall maximums apply. The commissioner will notify the provider in writing and the respective local social services agencies of the final rate determined under these rules and the effective date of such rate. Included in the notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

Statutory Authority: *MS s 256B.04; 256B.27; 256B.41*

History: *L 1994 c 631 s 31*

9510.0060 ADJUSTMENTS FOR ERRORS OR OMISSIONS.

All rates determined according to parts 9510.0010 to 9510.0470 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by part 9510.0150, subpart 9. Such adjustments are limited to the three complete fiscal years preceding the date an audit commences. If the adjustment results in a payment from the provider to the local social services agencies, the provider will have up to 120 days from the date the provider receives written notification of the adjustment. If the adjustment results in a payment to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

Statutory Authority: *MS s 256B.04; 256B.27; 256B.41*

History: *L 1994 c 631 s 31*

9510.0070 SPECIAL RATE SETTING PROCEDURES FOR NEW FACILITIES.

Subpart 1. **Required reports.** Providers with newly constructed facilities may request an interim welfare rate. Providers who increase the facility's capacity by at least 50 percent may at their option be considered in this classification. The provider must submit reports as required in part 9510.0150, subpart 1 for the immediate future fiscal year forecast results.

Subp. 2. **Report compliance.** Reports will comply with all applicable parts governing cost finding, reporting, and allowable costs to the extent feasible in the individual circumstances. Noncompliance with any provision of these rules must be so stated together with the reason why the provider cannot comply.

Subp. 3. **Interim rate establishment.** The commissioner will establish an interim rate in accordance with part 9510.0020 retroactive to the first day a medical assistance recipient is placed in the home. Such rate shall be subject to retroactive upward or downward adjustment in accordance with all provisions of parts 9510.0010 to 9510.0470 except part 9510.0030, subpart 2 on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with parts 9510.0040 and 9510.0150, subpart 9.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0080 RATES FOR LESSER CARE LEVELS IN FACILITIES WITHOUT CERTIFICATION CLASSIFICATION.

Providers who provide care to welfare recipients requiring less care than the care level to which the provider is certified will receive a per diem rate as follows:

A. ICF I care per diem rate in a skilled nursing care facility will not exceed 85 percent of the established skilled nursing care rate for that facility except that facilities whose skilled rates are affected by part 9510.0130, subpart 3, item B shall receive up to 85 percent of what their skilled rate would have been without application of part 9510.0130, subpart 3, item B.

B. ICF II care per diem rate in an ICF I facility will not exceed 60 percent of the established ICF I rate for that facility.

C. ICF II care per diem rate in a skilled nursing care facility will not exceed 50 percent of the established skilled nursing care rate for that facility.

This provision shall be applied in conjunction with part 9510.0190, subpart 2.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0090 PRIVATE ROOM RATE.

A private room rate of 115 percent of the established welfare per diem rate for the applicable care level in an individual home shall be allowed for a medical assistance recipient when deemed a medical or other necessity for the individual patient or as the patient's condition affects others; such condition must be determined by the attending physician and approved by the local social services agency. This provision, together with the provisions of part 9510.0470, subpart 4, shall apply only to facilities applying for a certificate of need after August 15, 1972.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1994 c 631 s 31*

9510.0100 CARE CLASSIFICATION ADDITIONS.

Providers who add certified care classifications may file an amended report under part 9510.0150 that includes known cost changes associated with care classification additions to obtain a welfare per diem rate for care not previously provided. The provider has the option of accepting the lesser care rates under part 9510.0080 in lieu of filing reports according to this provision.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *17 SR 1279*

9510.0110 ELECTION OF FLAT RATE FOR SMALL PROVIDERS.

Providers with a capacity of less than 30 licensed beds may annually elect to receive a flat per diem rate for providing required care of welfare patients by filing a flat rate report in lieu of receiving a rate complying with reporting requirements of part 9510.0150 and otherwise being subject to provisions of parts 9510.0010 to 9510.0470. The flat rate for skilled, ICF I, and ICF II for each region or group of regions as defined in part 9510.0130, subpart 2 shall be the regional average rates as determined from filed reports before the maximum rate limitation and excluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins. Such an election must be filed within reporting deadline provided by part 9510.0150, subpart 5 or be subject to penalty provisions of part 9510.0150, subpart 6. Such rates elected by providers will be in effect for one year.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0120 INCIDENTAL WELFARE RATE.

Providers may elect to receive a flat rate under part 9510.0110 for care of welfare recipients if welfare recipients account for less than 20 percent of the certified capacity of the home.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0130 RATE LIMITATIONS.

Subpart 1. **Limitation based on private pay rates or relevant federal or state laws and rules.** Notwithstanding any other provisions of these rules, the established provider

rates for nursing home care will not exceed the normal provider's rate charged private patients for comparable nursing care services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited by federal and state laws or regulations that affect the medical assistance program.

Subp. 2. **Maximum rate.** Individual welfare rates will be subject to a maximum of 125 percent of regional average costs plus known cost changes exclusive of this limitation and flat rates under part 9510.0110. Regions will be those areas designated by the governor for regional planning and economic development purposes. Regions may be combined when deemed appropriate by the commissioner as announced through policy bulletins. The regional averages will be calculated separately for proprietary, nonproprietary, and hospital attached facilities except the regional average costs for hospital attached facilities shall be included in the regional average calculation for nonproprietary free–standing facilities. The maximum rate limitations will be adjusted annually through policy bulletins. The regional averages will be determined by the commissioner, using all available information from reports that indicate a fiscal–year end during a calendar year and will be applied to rates that become effective during the second succeeding calendar year. Facilities that have a noncalendar–year end and have been previously subject to the maximum rates may adjust the rates to the new maximum rates if previously justified by the reports.

Subp. 3. **Maximum rate exceptions.** Welfare per diem rates in excess of the maximum rate limitation will be allowed in the initial year to the extent that the welfare rate requested includes cost increases required to increase wages to the minimum standards of federal or state wage laws.

Subpart 2 will not apply to homes that qualify for exception under part 9510.0460, subpart 4, item C or facilities licensed under parts 9570.2000 to 9570.3600.

Subpart 2 will not apply to providers with newly constructed facilities or providers who increase the facility's capacity by 50 percent for the first two immediate fiscal years.

A welfare per diem rate component in excess of either of the maximum rate limitations contained in subpart 2 will be allowed to the extent of 85 percent of the first $2 per patient day over the maximum welfare rate when total allowable costs are divided by actual patient days or 93 percent of total capacity patient days, whichever is greater provided that in no event shall this section affect a per diem rate by more than $1.70.

Subpart 2 will not apply to those salary cost changes which exceed six percent of the historical salaries if the salary cost changes are reasonable and are required to bring facility salaries to the salary range of comparable facilities. The salary cost changes for top management compensation are excluded from this exception.

Subp. 4. **Minimum rate.** The minimum welfare per diem rates will be 75 percent of the regional average as defined in subpart 2.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0140 APPEAL PROCEDURES.

Subpart 1. **Scope of appeals procedures.** These procedures describe the manner by which unresolved individual provider or local social services agency disputes that may arise concerning application of these rules excluding this part will be settled. Unresolved disputes are defined as those disagreements which cannot be resolved informally between the provider and the department staff normally assigned responsibility for administration, or the provider and a local social services agency.

Subp. 2. **Time limit.** The provider, or the county, has 30 days to appeal from the date of the department's notification of the new per diem rate. Appeals will be heard by an administrative law judge of the Office of Administrative Hearings and will be according to rules of that office in addition to the provision of this part.

Subp. 3. **Effective date of resolved disputes.** If the dispute is related to a change in the provider's rate, the new per diem rate will prevail until final determination according to these

appeal procedures is made. The total dollar amount due the provider or the department resulting from the resolved disputes will be subject to payment provision of part 9510.0060.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1984 c 640 s 32; L 1994 c 631 s 31*

9510.0150 GENERAL REPORTING REQUIREMENTS AND SUBMITTAL PROCEDURES.

Subpart 1. **Required reports.** Except as provided by parts 9510.0110 and 9510.0120 to receive a per diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the department. Reports, supporting documentation, and worksheets will consist of the following:

A. general provider information and statistical data;

B. financial statement consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations;

C. reports of historical costs and known cost changes together with supporting calculations and worksheets;

D. rate determination worksheets;

E. other relevant data may be required by the commissioner to support a welfare rate request (if such data are not provided within 30 days, the commissioner must calculate a rate, making whatever assumptions deemed appropriate to arrive at the rate in the absence of the requested data);

F. a complete statement of fees and charges; and

G. the names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

Specific report formats and preparation instructions will be contained in a provider manual prepared and revised periodically by department personnel. Copies of said manual will be made available to all interested parties through the Print Communications Division of the Department of Administration. Newly established providers or providers who change their fiscal year must file short–period reports if the period covered is more than five months.

Subp. 2. **Method of accounting.** The accrual basis of accounting in accordance with generally accepted accounting principles shall be the only method acceptable for purposes of satisfying reporting requirements. In a unique situation, such as the use of government providers, the use of the accrual basis of accounting may not be applicable. In such an instance, the commissioner may permit the provider to use a cash or modified cash basis of accounting if the provider can establish that no difference in rate would result.

Subp. 3. **Records.** The provider will maintain statistical and accounting records to support information in no less detail than that required by subpart 1 required reports for at least three years following submission of a cost report. The provider shall also make available federal and state income tax returns upon request of department personnel.

Subp. 4. **Report certification.** Reports required in subpart 1 will be accompanied by a certification of the majority owner defined as the person having over 50 percent effective ownership, or the chief financial officer if there is no majority owner; and the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.

If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitted as a part of reports required by subpart 1.

Subp. 5. **Reporting deadlines and extensions.** Required reports shall be submitted directly to the department within three calendar months after the close of the provider's normal fiscal year. A final rate will be established within 30 days of receipt by the department of complete and accurate reports and required documentary information.

The department may reject any report that is incomplete or inaccurate within 30 days of receipt. In such case, the department will establish a temporary rate in accordance with part 9510.0050 to be paid until the information is completely and accurately filed.

The commissioner may grant exceptions to the reporting deadline for just cause. A routine extension of 60 days will be granted when a written request is received by the department prior to the reporting deadline.

Subp. 6. **Penalties.** Penalties include:

A. Report preparation and submittal. The penalty for noncompliance with subparts 1 and 5 will be to reduce the reimbursement rate to 80 percent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the commissioner.

B. False reports. Incorrect or false information supplied by the provider on required reports resulting in overpayments to the provider will result in one or more of the following:

(1) immediate adjustment of the welfare rate, along with retroactive recovery by the local social services agency of funds incorrectly paid to the provider;

(2) termination of the provider contractual agreement; and

(3) prosecution under applicable federal and Minnesota statutes.

Subp. 7. **Audits.** All reports will be subjected to desk audit and at least every three years will be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider recordkeeping and accounting practices, the commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of subpart 6, item A or B may be applied to ensure compliance with this provision.

Subp. 8. **Application of reasonable cost principles.** Reports required by subpart 1 must be prepared in accordance with reasonable cost principles in parts 9510.0230 to 9510.0450.

Subp. 9. **Amended reports.** Except as provided in the last paragraph of part 9510.0030, subpart 3, providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage laws changes occur unexpectedly or when long term labor contracts expire and are renegotiated subsequent to the reporting deadline in subpart 5, item A. The cost change omissions to comply with minimum wage law changes or labor contracts will be limited to the wage increases required to meet the minimum standards of federal or state wage laws or reasonable labor agreements. Such changes in the welfare per diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less, for each annual period. The payment and period covered by this provision are governed by part 9510.0060.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1994 c 631 s 31*

9510.0160 SPECIAL PROVISIONS FOR MULTIHOME PROVIDERS AND PROVIDERS INVOLVED IN OTHER BUSINESS ACTIVITIES.

Subpart 1. **Reporting exceptions.** Providers who operate several homes or who are engaged in activities other than nursing care may not be able to comply with the required reports referred to in part 9510.0150, subpart 1. In that case, the provider must indicate reasons for noncompliance.

Subp. 2. **Charges from related organizations.** Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. If the related organization in the normal course of business sells services, facilities, or supplies to the outsiders, the cost to the provider shall be the outsider's price; however, sales to outsiders must constitute at least 25 percent of its sales.

Subp. 3. **Cost allocation of top management salaries and management fees.** The allocated portion of compensation for the chair of the board, directors, presidents, or other similarly titled individuals allocated to an individual nursing home shall be subject to the limitation provided in part 9510.0340, subpart 2. Other corporate charges or costs allocated to a nursing home must represent the cost of services actually rendered and be identified as to the type of service provided.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *17 SR 1279*

9510.0170 CARE CLASSIFICATIONS AND DEFINITIONS.

The following care classifications are used in cost reporting required by these rules. The definitions of these terms included in parts 9500.0750 to 9500.1080 and appropriate federal regulations governing title XIX are hereby adopted: Skilled Nursing Home (Skilled), Intermediate Care Facility I (ICF I), and Intermediate Care Facility II (ICF II).

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0180 COST CATEGORIES.

Subpart 1. **In general.** Costs used for rate–setting purposes and related to patient care are to be grouped according to major cost categories used in required reports. Such categories are defined as follows.

Subp. 2. **Nursing.** All directly identifiable costs associated with nursing care defined in part 9510.0170. In general, these include bedside care; administration of medications, irrigations, and catheterizations; application of medications, dressings, or bandages; rehabilitative nursing techniques; and definition of modified diets, as well as other treatments prescribed by a physician that require professional or technical knowledge, skills, and judgment as possessed by a professional nurse. Included are comfort medications, medical supplies, devices, and other routine supplies not separately reimbursed as listed in subpart 9. Personnel costs to be included in nursing are the salaries of the director of nursing, supervising nurses, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants (ICF II care only). The salaries or fees of physicians performing consulting services not reimbursed by separate fee schedule are also to be included in this cost category.

Subp. 3. **Dietary.** All directly identifiable costs of normal and special diet food including food preparation and serving. Personnel costs to be included in dietary are the salaries of dietitians, chefs, cooks, dishwashers, and all other employees assigned to the kitchen and dining room.

Subp. 4. **Laundry and linen.** All directly identifiable costs of linen and bedding, laundering and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, sewing workers, launderers, and ironers.

Subp. 5. **Housekeeping.** All directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, domestics, and other cleaning personnel.

Subp. 6. **Plant operation and maintenance.** All directly identifiable costs for maintenance and operation of the buildings and grounds, including fuel, electricity, water, supplies and parts to repair and maintain equipment and facilities, and tools. Personnel costs to be included are the salaries of engineers, painters, heating–plant employees, plumbers, electricians, carpenters, and security personnel.

Subp. 7. **Other care–related services.** All directly identifiable costs of other services, such as recreational activities, religion, rehabilitation, arts and crafts, and social services.

Subp. 8. **General and administration.** All directly identifiable costs for administering overall activities of the facility, including business–office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefit costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified under definitions in part 9510.0180.

Subp. 9. **Miscellaneous nonreimbursable services and expenses.** Miscellaneous nonreimbursable services and expenses include the following:

A. All directly identifiable costs of functions normally reimbursed by charges to patients, employees, or outsiders, such as the operating costs of a pharmacy, beauty shop, or coffee and gift shop are included here.

B. Also included are specific costs that may be incurred by the provider and reimbursed separately according to a fee schedule. These include but are not limited to the following:

(1) services provided by licensed medical, therapeutic, or rehabilitative practitioners;

(2) oxygen at prevailing prices; and

(3) wheelchair alterations for specific medical assistance recipients.

C. Also included in this part will be costs associated with operating activities financed by gifts or grants from private or public funds.

D. All costs classified in this subpart are not allowable for purposes of determining a per diem rate under parts 9510.0010 to 9510.0480.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *17 SR 1279*

9510.0190 PATIENT DAYS.

Subpart 1. **Definition.** For purposes of determining a per diem rate, a "patient day" is defined as a day for which full and normal billings were rendered.

Subp. 2. **Special care rates.** Facilities that provide care to a patient requiring less care than the care level to which the facility is certified may adjust lesser–care patient days for rate–calculation purposes as follows:

Level of Care Provided	Certification	
	Skilled	ICF I
Skilled	1.00	N/A
ICF I	.85	1.00
ICF II	.50	.60

The lesser care patient day adjustment cannot exceed 15 percent of actual patient days. This limitation may be waived temporarily to accommodate a transition period during which the provider obtains the proper facility certification.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0200 GENERAL COST ALLOCATION PROCEDURE FOR ALL PROVIDERS.

Costs will be classified in accordance with categories defined in part 9510.0180 and, if applicable, by care level defined in part 9510.0170.

Classification of costs to cost categories part 9510.0180 will involve one or more of the following steps:

A. Direct identification, without allocation, which will be accomplished in the routine classification of transactions when costs are recorded in the books and records of the provider.

B. In instances in which individuals have multiple duties, the person's salary cost will be allocated to categories part 9510.0180 on the basis of management's estimate of time spent on various activities. This procedure will not be applied to administrators or other chief executives' salaries in facilities with 60 or more licensed beds.

C. Other costs that cannot be classified to cost categories through use of procedures in items A and B will be classified in the administrative category.

Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in part 9510.0180, subpart 9.

Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in parts 9510.0230 to 9510.0450 of these rules. All adjustments will be footnoted with the applicable rule number. Costs previously excluded by part 9510.0180, subpart 9 will not require further adjustment.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0210 SPECIFIC CARE LEVEL ALLOCATION PROCEDURES FOR MULTILEVEL PROVIDERS.

Subpart 1. **Purpose and definition.** Cost allocation procedures are necessary to determine costs among different care level facilities. Allocation procedures are defined in the following subparts and will be applied in the order stated except where noted otherwise. Regardless of method selected, a reasonable identification of costs to care level must result.

Subp. 2. **Nursing care.** Any combination of allocation procedures in items A to C can be used as long as the result is a reasonable approximation of actual costs incurred by care level:

A. Direct identification (without allocation) in the routine classification of transactions when costs are recorded in the books and records of the provider (e.g., invoice and time record account classification).

B. Cost allocation on the basis of regularly validated time or cost studies.

C. Remaining costs (e.g., nursing supervisor, supplies, etc.) not classified under methods in item A or B will be allocated on the ratio of costs identified to care levels (using item A or B), one care level to another.

D. If methods in items A to C cannot be used, costs will be allocated on the basis of actual patient days weighted by the ratio of maximum allowable nursing care and attendant hours as defined in parts 9510.0310 to 9510.0330.

Subp. 3. **Dietary.** The following allocations apply:

A. cost allocation on the basis of regularly validated time or cost studies;

B. cost allocation based on the number of meals served; and

C. cost allocation based on the actual patient days.

Subp. 4. **Laundry and linen, housekeeping, and plant operation and maintenance.** The following allocation procedures can be applied to individual department costs or the combination of these three departments at the option of the provider:

A. same as subpart 2, item B, time or cost studies;

B. allocation on the ratio of square feet of floor space devoted directly to each care level; and

C. same as subpart 2, item C, patient days.

Subp. 5. **Other care related services.** The following allocations apply:

A. same as subpart 2, item B, time or cost study; and

B. same as subpart 2, item C, patient days.

Subp. 6. **General and administration.** Cost allocation on the ratio of the combined cost by care level determined for categories subparts 2, 3, 4, 5, and 7.

Subp. 7. **Depreciation, interest, and real estate and personal property taxes.** The following allocations apply:

A. Location of equipment when determinable.

B. Same as subpart 4, item B, square feet.

C. Same as subpart 3, item C, patient days. This allocation procedure must be used if actual patient days in any care level exceeds certified capacity patient days.

Subp. 8. **Earnings allowance.** The following cost allocations apply: Cost allocation on the ratio of the combined cost by care level determined for categories subparts 2, 3, 4, 5, and 7.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0220 HOSPITAL ATTACHED FACILITIES.

Hospital attached facilities will include those facilities which are under common ownership and operation with a licensed hospital and are required to adhere to uniform cost re-

porting for governmental reimbursement programs. Common operation shall be defined as the sharing of services, such as nursing services, dietary, housekeeping, laundry, plant operations, and/or administrative. The nursing care limitation under part 9510.0310 and the investment per bed limitation under part 9510.0360, subpart 1 will be waived when the Medicare cost allocation factors result in these limitations being exceeded. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups: all expense classifications without depreciation, administration and general; depreciation; administration and general.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0230 REASONABLE COSTS.

Costs to be allowable for rate setting purposes must satisfy the following overall criteria:

A. They must be necessary and ordinary costs related to patient care.

B. They must be costs that prudent and cost–conscious management would pay for a given item or service.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0240 COSTS NOT ALLOWABLE.

Costs that relate to management inefficiency, unnecessary care or facilities, and activities not common and accepted in the nursing care field are not allowable.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0250 REASONABLE COMPENSATION.

Reasonable compensation of individuals employed in the facility is an allowable cost, provided the services are actually performed in a necessary function and the costs reported are actually incurred. To be reasonable the compensation allowance must be such an amount as would ordinarily be paid for comparable services by comparable facilities. To be necessary the function must be such that had the individual not rendered the services, the facility would have had to employ another person to perform the services. The function must also be pertinent to the operation and conduct of the facility. Where the services are rendered on less than a full–time basis, the allowable compensation should reflect an amount proportionate to a full–time basis. Compensation shall include payment to individuals as well as to organizations of nonpaid workers that have arrangements with the provider for the performance of services by nonpaid workers.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0260 SUBSTANCE PREVAILS OVER FORM.

The cost effect of transactions that are conceived for the purpose of circumventing parts 9510.0010 to 9510.0480 will be disallowed under the principle that the substance of the transaction shall prevail over form.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0270 COSTS DUE TO CHANGES IN FEDERAL OR STATE REQUIREMENTS.

Costs incurred to comply with the changes in federal or state laws and rules on increased care and improved facilities are allowable costs for purposes of determining a historical per diem rate under part 9510.0030, subpart 1.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0280 REDUCTION IN COSTS.

Purchase discounts, allowances, and refunds are a reduction of the cost of whatever was purchased.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0290 ANNUAL REVIEW OF COST LIMITATIONS.

The commissioner shall review annually the dollar limitations for top management compensation limitation part 9510.0340, subpart 2 and depreciation basis limitation part

9510.0360 and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0300 APPLICATION OF PRINCIPLES AND SPECIFIC LIMITS.

The reasonable cost principles defined in parts 9510.0230 to 9510.0290 apply to all reported costs and have been specifically defined for certain cost elements in parts 9510.0310 to 9510.0470.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0310 NURSING CARE LIMITATIONS.

Nursing care costs will be limited by a maximum number of nursing hours per patient day as follows: Skilled, 2.9 hours; ICF I, 2.3 hours.

If the actual average nursing hours per patient day exceed the above limit, the reasonable cost limitation will be calculated by multiplying the ratio of the above stated limit to the average actual nursing hours per patient day for the year times the actual cost per patient day. This limitation will not apply to facilities that qualify for exception under part 9510.0470, subpart 4, item C or facilities licensed under parts 9570.2000 to 9570.3600, or facilities mandated by a correction order from the Department of Health to provide additional nursing care.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0320 ATTENDANTS (ICF II FACILITIES ONLY); LIMITATIONS.

Reasonable costs for attendants in ICF II facilities will be limited to one hour per patient day. If the actual average attendant hours per patient day exceeds this limit, the reasonable cost limitation will be calculated by multiplying the ratio of the stated limit to the average actual attendant hours per patient day for the year times the actual cost per patient day.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0330 LIMITATION EXCEPTION.

The nursing and attendant care limits established in parts 9510.0310 and 9510.0320 may be exceeded as described below:

A. The Department of Human Services shall establish the 1980 per diem in accordance with parts 9510.0310 to 9510.0330.

B. Increased nursing and attendant care hour costs may only be funded through expenditure reductions in the following cost categories as defined in parts 9510.0170 to 9510.0190 and as subject to the limitations prescribed elsewhere in parts 9510.0010 to 9510.0480: dietary, laundry and linen, housekeeping, plant operation and maintenance, other care related services, and general and administration.

Amounts for which a known cost increase has been granted shall not be included in these calculations. Reductions from historical costs in these categories will be recognized.

C. Subsequent years' rates will be determined based on actual nursing and attendant care limits to the extent that they equal reported actual cost reductions in the categories identified in item B.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1984 c 654 art 5 s 58*

9510.0340 GENERAL AND ADMINISTRATIVE EXPENSES.

Subpart 1. **In general.** Reasonable cost criteria for general and administrative expenses are as follows.

Subp. 2. **Top management compensation limitation.** Top management compensation includes that of owners, administrators, president, chair of the board, board members, or other individuals receiving compensation as executives but not performing duties of a department head. Compensation includes the costs of noncash compensation such as residences, salaries, and deferred compensation except IRS qualified pension or profit–sharing plans. The average annual cost limitation for rate–setting purposes on compensation is determined according to the average number of combined licensed nursing home and boarding care beds according to the following schedule:

Number of Beds	Cumulative Annual Compensation Per Bed Limitation
First 50	$264
Next 51–100	132
Over 100	66

The minimum annual compensation limitation is $10,000 or actual compensation, whichever is less, and the maximum shall be $35,000. For each full percentage point increase in the Consumer Price Index in Minneapolis–Saint Paul as published by the Bureau of Labor and Statistics for the months October 1973 and October 1974, new series index (1967 = 100), the accumulation annual compensation per paid limitation listed above shall be increased by one percent. The increase, if any, generated by this formula shall be affected in January 1, 1975. Similar calculations shall be made for each successive year using the October indices for two successive years with the increases beginning effective the following January.

Subp. 3. **Assistant administrator.** Reasonable compensation of assistant administrators is not subject to the limitation in subpart 2.

Subp. 4. **Other management services.** The costs of other directors' fees, unidentified management fees, and physician compensation for performing administrative functions are allowable to the extent that such costs together with compensation of top management do not exceed the limitations defined in subpart 2.

Subp. 5. **Other general and administrative costs.**

A. Owners life insurance: the costs of premiums are not allowable.

B. Personal expenses of owners or employees, such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation do not exceed the limitations of parts 9510.0250 and 9510.0340, subpart 2.

C. Professional, technical, or business–related organizations. These costs are allowable if their function and purposes can be reasonably related to the development and operation of nursing facilities, patient care facilities, and programs for the rendering of patient care services.

D. Social, fraternal, and other organizations. Costs incurred in connection with memberships in all organizations not included in item C are not allowable.

E. Travel and automobile. These expenses are not an allowable expense unless they are related to activities of managing the nursing home.

F. Entertainment. These expenses are not allowable costs.

G. Pension and profit–sharing plans. Contributions to either an Internal Revenue Service approved pension or profit–sharing plan, but not both, are allowable costs.

H. Employee education costs, orientation, and on–the–job training. Costs relating to providing improved patient care or, where required by state law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories, part 9510.0180 unless not identifiable.

I. Training programs for nonemployees. Costs of training programs conducted for nonemployees other than for volunteers are not allowable.

J. Telephone, television, and radio service. These are allowable costs where furnished to the general patient population in areas of provider day rooms, recreation rooms, lounges, etc. The cost of these services when located in a patient accommodation is not allowable.

K. Noncompetitive agreement. Costs of these agreements are not allowable.

L. Preopening costs. One time preopening costs of new facilities incurred prior to admittance of patients must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period no less than 120 consecutive months beginning with the month in which the first patient is admitted for care. Examples of these costs are wages paid prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.

M. Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.

N. Fundraising costs. Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by part 9510.0440, subparts 1 to 6.

O. Charitable contributions. These are not allowable costs.

P. Other general and administrative costs. As provided in Minnesota Statutes, section 256B.47, subdivision 2, the following shall not be recognized as allowable costs unless otherwise noted:

(1) Political contributions made by a health care facility or institution shall not be recognized as allowable.

(2) The salary of an individual in the employ of a facility shall be allowed for lobbying activities as defined in Minnesota Statutes, section 10A.01, subdivision 11 only if the lobbying activity is incidental to the individual's job functions and if such lobbying directly relates to the licensed and certified functions of the facility.

(3) Reasonable yellow pages listings, brochures, flyers, newsletters, and other similar items which are primarily designed to describe the services, licensure, accreditation, staffing, and other similar matters concerning the facility are allowable costs.

(4) Assessments levied and collected by the Minnesota Department of Health shall not be recognized as allowable costs.

(5) Legal fees for unsuccessful challenges to decisions by state agencies.

(6) Association dues are allowable only if they directly relate to patient care. For purposes of this section, directly related to patient care means activity which the nursing home clearly demonstrates is a necessary part of the licensed or certified function of the nursing home or directly leads to improved quality of care or improved administrative operations.

Each association for which dues are claimed as an allowable cost must file annually with the department a statement summarizing its activities, its revenues generated by dues, and its expenditures of funds received from dues payments. The percentage (up to 100 percent) of dues revenue which the association expends for direct care purposes as defined above will be allowed during the next year. The statement must be filed within 30 days of the end of the association's fiscal year except that in order for dues to be allowable effective September 1, 1977, each association must file such a statement by October 1, 1977, covering its most recently completed fiscal year. This provision of the rule is effective for rates paid on September 1, 1977.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *17 SR 1279*

9510.0350 DEPRECIATION; BASIS FOR CALCULATION.

Subpart 1. **Cost.** Historical cost of nursing facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by subpart 2.

Subp. 2. **Change in ownership of facilities.** In a case in which a change in ownership of a nursing home facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:

A. In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of:

(1) the portion of the purchase price properly allocable to depreciable nursing home facilities; or

(2) the appraised value of the depreciable nursing home facilities calculated under the replacement cost, depreciated method.

B. In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of item A the case of a complete change in ownership except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial

change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 percent. Any increase allowed by this section will then be adjusted according to subpart 6.

Subp. 3. **Redemption of ownership interests.** In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying the provision of subpart 2, item B.

Subp. 4. **Donated assets.** The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price that an able buyer would pay a willing seller in an arms–length sale or appraised value defined in subpart 2, item A, subitem (2), whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

Subp. 5. **Subsequent acquisitions.** The basis for calculating depreciation may be increased for the actual cost of equipment additions or facility modification or renovation.

Subp. 6. **Recapture of depreciation resulting from sale of facility.** The sale of depreciable nursing home property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation calculated in accordance with parts 9510.0350 to 9510.0420 indicates the fact that depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture will be determined as follows:

A. The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after November 1, 1972.

B. The gross recapture amount as determined in item A shall be allocated to fiscal periods from November 1, 1972, through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under parts 9510.0010 to 9510.0480. The amount allocated to each period shall be divided by the total actual patient days in that period, thereby determining a patient–day cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the patient–day cost for each fiscal period.

C. The total net recapture amount determined according to item B will be reduced by one percent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the state of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of subpart 2.

The net recapture amount so determined in item C will be paid by the new owner to the state of Minnesota within a time period agreed to by the commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

Subp. 7. **Gains and losses on disposition of equipment.** Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these rules. Gains or losses on trade–ins should be reflected in the asset basis of the acquired asset. Losses will be limited to five cents per patient day annually; however, any excess over this limitation can be carried forward to future years.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0360 LIMITATIONS ON DEPRECIATION.

Subpart 1. **Maximum depreciable basis.** The total basis of depreciable nursing facility assets shall not exceed an average of $13,000 per bed for licensed beds in two or more beds per room and $19,500 per bed for licensed private rooms built or purchased after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975, according to a construction index as determined by the commissioner. The depreciable basis for licensed beds built or purchased prior to January 1, 1974, shall not exceed an average of $11,000 per bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private

room which satisfy the certificate of need provision of part 9510.0090. However, the depreciable basis for licensed private rooms built prior to August 15, 1972, shall not exceed an average of $16,500 per bed for a maximum of five percent of licensed beds. In no instance can accumulated depreciation calculated in accordance with parts 9510.0350 to 9510.0420 exceed the basis defined in part 9510.0350.

Subp. 2. **Accumulated depreciation.** Accumulated depreciation as of the beginning of the first fiscal year covered by parts 9510.0010 to 9510.0480 shall be calculated retroactively using the useful life concept defined in parts 9510.0370 and 9510.0380.

Subp. 3. **Other depreciation allowed.** Regardless of the applicability of the limitation stated in subpart 1, depreciation on investments in facility modifications and new equipment will be allowed if they were required by governmental requirements.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0370 DEPRECIATION RATES FOR NEW FACILITIES AND EQUIPMENT.

Depreciation shall be calculated using the basis determined under part 9510.0350 applying one of the "useful life" schedules defined in item A or B.

A. Building, 35 years:

(1) major building improvements, depreciated over the remaining life of the principal asset or useful life, but not less than 15 years;

(2) land improvements, 20 years;

(3) equipment, ten years; and

(4) vehicle, four years.

B. American Hospital Association depreciation guidelines.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0380 OTHER USEFUL LIVES.

Subpart 1. **Depreciation rates for used facilities and equipment.** The useful life shall be assigned by the provider considering the individual circumstances; however, the useful life will not be shorter than one–half of the useful life provided by part 9510.0370, item A or B.

Subp. 2. **Leasehold improvements.** The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0390 DEPRECIATION METHOD.

The straight–line method of depreciation should be used except, at the option of the provider when the principal payments on capital indebtedness (as defined in part 9510.0440, subpart 1) exceed the total depreciation allowance calculated in accordance with parts 9510.0350 to 9510.0420. In such instances, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and six years for equipment. Accumulated depreciation cannot exceed the basis defined in part 9510.0350. Depreciation on any new construction or expansion of facilities commenced on or after January 1, 1977, other than governmentally owned facilities, shall be on a basis of not less than 30 years. For facilities constructed or expanded prior to January 1, 1977, and for facilities purchased after January 1, 1977, presently existing depreciation rules will apply.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0400 FACILITIES FINANCED BY PUBLIC FUNDS.

Depreciation will not be allowed on the portion of facilities financed by federal, state, or local appropriations or grants unless the intent of such appropriation or grant was that to be repaid through operating revenue of the facility. This limitation will not apply to governmentally owned nursing homes.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0410 NONDEPRECIABLE ASSETS.

Nursing facility assets that are not depreciable include but are not restricted to:

A. Land. This includes the land owned and used in provider operations included in the cost of land and the costs of permanent roadways and grading of a nondepreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a nondepreciable nature.

B. Goodwill. This includes amounts that result from purchase of property or stock in excess of determinable value as determined in part 9510.0350, subpart 2.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0420 CAPITALIZATION VS. EXPENSE.

Expenditures for equipment that has a useful life of more than one year shall be capitalized except that the provider may show as expenses small equipment purchases normally capitalized if such items do not exceed two cents per patient day annually.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0430 LEASED FACILITIES OR EQUIPMENT.

Subpart 1. **Rental charges.** Reasonable rental charges incurred by a provider through a lease entered into an arms length transaction are includable in allowable costs unless:

A. Rental charges result from a sale, lease–back arrangement, or lease with option to buy at a price less than anticipated value.

B. Rental charges are paid to a related or controlled organization. If either item A or B exists, the provisions of subpart 2 will be applied.

Subp. 2. **Disallowance of rental charges.** If rental charges are not allowed, the rate of the provider will be determined as for any other provider as though the lease did not exist. In this case allowable costs would include both costs of the lessor and the lessee.

Subp. 3. **Limitation.** Allowable rental charges are subject to the investment per bed limitations of part 9510.0360, subpart 1 determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of the federal hospital insurance fund obligations as of the effective date of the lease. The formula for determination of this provision is as follows:

A. present value of lease = lease payment per period x present value factor per period; and

B. investment per bed = present value of lease — licensed beds.

The present value factor can be determined from annuity tables according to the present worth of $1 per period for the term of the lease.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0440 COST OF CAPITAL.

Subpart 1. **Interest.** Except as provided in subpart 6 interest is an allowable cost for nonproprietary facilities only and will be classified as follows:

A. Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchase fixed assets related to providing nursing care as defined in part 9510.0450, subpart 1. The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

B. Other interest for working capital and operating needs that directly relate to providing nursing care is an allowable cost. The form of indebtedness will include, but not limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.

Subp. 2. **Interest income.** Interest income will be a deduction from interest allowable under subpart 1, item A or B. Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpected donated funds carried by the institution that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

Subp. 3. **Interest rate.** The interest rate incurred must not be in excess of what a borrower would have had to pay in an arms–length transaction in the money market when the

loan was made. When a nonproprietary provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is allowable at a rate not to exceed the interest rate the fund is currently earning. Interest on liens between operating and building funds is not allowable.

Subp. 4. **Construction interest.** Interest cost incurred during and related to construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

Subp. 5. **Former nonproprietary or governmentally owned nursing home.** After the first three years that a nonproprietary or governmentally owned nursing home has been owned by its current owners, the state agency shall not recognize as an allowable cost the expense of interest on net debt for any indebtedness and loans which exceed 100 percent of the net asset value of the facility. Effective July 1, 1977, interest expense on indebtedness incurred prior to April 13, 1976, is exempted from this provision if the expense is allowable according to subpart 1.

Subp. 6. **Proprietary nursing home.** Interest expense for a proprietary nursing home will be allowable on capital indebtedness to the extent that the rate of interest exceeds nine percent, but no more than 12 percent, if the indebtedness relates directly to the purchase of the nursing home or to working capital for the operation of the nursing home and if the rate of interest does not exceed a rate which a prudent and cost–conscious borrower would incur in an arms–length transaction.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0450 INVESTMENT ALLOWANCE.

Subpart 1. **Determination of allowance.** Effective July 1, 1980, proprietary homes shall receive an investment allowance of 11.1 percent of the original value of the facility for depreciation purposes. For each year after the year in which the nursing home was originally purchased in which there is no transfer of ownership of a nursing home, the investment allowance shall be increased by one percent of the original investment allowance, but the increases shall be limited to a maximum of 25 percent of the original investment allowance effective for rates paid on August 1, 1977.

Subp. 2. **Definitions.** For purposes of this part the following terms shall have the meaning given to them:

A. "Facility" means the building in which a nursing home is located and all permanent fixtures attached to it. Facility does not include the land or any supplies and equipment which are not fixtures.

B. "Original" value means the lesser of purchase price or appraised value at the time of purchase. Appraisals at the time of purchase shall be on the depreciated replacement cost basis. If a nursing home expands its facility or makes any other capital expenditure which increases the value of the facility, the cost of the expansion or capital expenditure shall be added to the original value. If the department disputes the cost of the expansion or capital expenditure, it may request an appraisal and use the appraised value as the allowed cost.

Subp. 3. **Allowance for leased facilities.** Leased facilities shall receive an investment allowance not to exceed the greater of 35 cents per the facility's 93 percent capacity patient days or the investment allowance of subpart 1 for those fixed assets owned by the lessee facility.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0460 WELFARE COSTS.

All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patients exclusively will be calculated in a manner that results in an assignment of the incremental costs stated above wholly to welfare patients. Such costs may include reasonable expenditures for utilization review, preparation, and processing of a cost statement under parts 9510.0010 to 9510.0480.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0470 FACILITY UTILIZATION INCENTIVES.

Subpart 1. **Capacity limitation.** The allowable cost amount per patient day depreciation, interest, property taxes, administration, and earnings allowance will be calculated by

dividing such allowable costs by 93 percent of total capacity patient days for licensed beds. Facilities qualifying for the special care rate of part 9510.0190, subpart 2 may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 percent of total capacity patient days for licensed beds.

Subp. 2. **Calculation of patient days.** For purposes of calculating patient days at 93 percent of licensed capacity and to assign a greater proportion of costs to private rooms, a factor of 1.5 times the number of licensed private beds will be used in determining the number of patient days. This provision shall apply only to facilities applying for a certificate of need after August 15, 1972.

Subp. 3. **Licensed bed capacity.** Usable or operable bed capacity may be used for purposes of the calculation required by subparts 1 and 2 if the provider can justify in writing, to the satisfaction of the commissioner that licensed beds is an inappropriate measure of capacity.

Subp. 4. **Waiver of limitation.** Providers may apply for a waiver of the provisions of subparts 1 and 2 in the following instances:

A. For new facilities or facilities with major changes in capacity, that are applying for a certificate of need after November 1, 1972, the commissioner may grant a waiver of this capacity calculation and allow a rate based on anticipated actual patient days for the period through the end of the first full fiscal year.

B. In cases of extreme hardship, nursing homes not covered by item A and having over 65 percent welfare patient days may be granted an annual waiver by the commissioner of this capacity calculation and be allowed a rate based on actual patient days. Extreme hardship will include a financial situation in which projected cash flow indicates the fact that debt and operating obligations cannot be met.

C. Skilled care facilities which have a patient population with an annual average length of stay of 180 days or less may be granted an annual waiver by the commissioner of this capacity calculation and be allowed a rate based on actual patient days. The average length of stay is determined by dividing the actual patient days for the historical fiscal year by the total discharges for the historical fiscal year.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

9510.0480 SEVERABILITY.

If any provisions of the rules as adopted by commissioner of human services are found to be unreasonable or not supported by the evidence, the remaining provisions shall remain valid.

Statutory Authority: *MS s 256B.04 subd 2; 256B.27; 256B.41*

History: *L 1984 c 654 art 5 s 58*

RATES FOR PROVIDERS OF RESIDENTIAL SERVICES FOR MENTALLY RETARDED PERSONS

9510.0500 STATUTORY AUTHORITY.

Parts 9510.0500 to 9510.0890 are enacted pursuant to the statutory authority vested in the commissioner of human services pursuant to Minnesota Statutes, section 256B.27, to require reports, information, and audits, and, pursuant to Minnesota Statutes, section 256B.04, subdivision 2, to promulgate rules for carrying out and enforcing the provisions of Minnesota Statutes, chapter 256B. These parts are further promulgated pursuant to the procedures set out in Minnesota Statutes, sections 14.05 to 14.36, of the Minnesota Administrative Procedure Act.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 654 art 5 s 58*

9510.0510 PURPOSE.

The procedures embodied herein define a system for the determination of a per diem welfare rate for all residential facilities for the mentally retarded with more than four beds participating in the medical assistance and cost–of–care program, except state institutions

that are governed by other state laws, that promotes efficiency and economy and treats all providers on a uniform basis. Facilities for the mentally retarded are defined as facilities licensed under the provisions of Minnesota Statutes, section 252.28. Facilities which provide care to other than mentally retarded residents must comply with these rules if mentally retarded persons account for more than 50 percent of the facility population. Procedures have been defined to satisfy the state plan for medical assistance and HEW Program Guide 19, which prescribe reasonable charge/cost related rate–setting methods. The rate–setting procedures have also been defined to comply with the state statute that requires that cost differences between individual providers be recognized (Minnesota Statutes, section 256B.04, subdivision 2) while at the same time establishing cost limitations to satisfy federal requirements requiring that the welfare rates be consistent with efficiency, economy, and quality of care.

The welfare rate–setting procedures included herein also recognize required residential classification and quality of care as defined by Department of Human Services licensing and federal certification standards, establish effective accountability over the disbursement of medical assistance appropriations, and provide for a regular review mechanism for rate changes.

While the rate–setting procedures are intended to compensate the provider for the reasonable costs incurred by prudent management including a return of capital through depreciation and earnings allowance, they are not intended to provide funds for financing working capital needs or purchase of facilities. It is not intended that the rules provide for reimbursement of actual costs through retroactive settlement.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 654 art 5 s 58*

9510.0520 METHOD OF CALCULATING WELFARE PER DIEM RATE.

Subpart 1. **Historical rate.** The method of calculating the per diem rate will be to determine reasonable costs for the most current fiscal year, except for the property and related costs, general and administrative costs, and the earnings allowance or minimum cost of capital allowance, and divide by actual resident days according to the reasonable cost provisions of parts 9510.0660 to 9510.0870 and cost–reporting rules contained in parts 9510.0590 to 9510.0650. Such rate shall be based on occupancy factor of no less than 80 percent. The 80 percent occupancy factor shall apply only to facilities of more than ten beds. The property and related costs, general and administrative costs, and the earnings allowance or minimum cost of capital allowance will be divided by 93 percent of total capacity resident days for licensed beds. For facilities of ten beds or less the facility may use actual resident days. This provision shall not be in conflict with part 9510.0560, subpart 3.

Subp. 2. **Incentive factor.** In no case will the historical rate so determined under subpart 1 be less than a comparable amount calculated for the previous year minus one–half of the difference. This provision shall not apply for rates for newly established providers under part 9510.0560.

Subp. 3. **Allowance for known cost changes.** Future cost increase or decreases known as of the report filing date must be added to or deducted from the historical rate determined according to subparts 1 and 2. Such adjustment will be restricted to the elements defined in items A to K and shall be the annualized cost effect of such cost changes exclusive of any portion of cost change included in the historical rate.

A. Salary and wage changes to occur during the effective period of the welfare rate:

(1) future changes according to labor contracts, board resolutions, written policies, or minimum wage laws; and

(2) changes that are in effect as of the end of the fiscal period covered by the historical cost portion of the welfare per diem rate.

B. Changes in facilities or equipment.

C. The annualized cost effect of complying with federal, state, or local laws and regulations on increased care or improved facilities.

D. Payroll and property taxes.

E. Interest.

F. Depreciation.

G. Utilities and insurance.

H. The cost effect of reductions and expansions to program services approved by the Department of Human Services.

I. Rental payments pursuant to a written lease.

J. A food cost change computed initially by multiplying the average of food services costs per day for available 1979 cost reports less the lower and upper ten percent times the percentage change in the Consumer Price Index for raw food costs in Minneapolis–Saint Paul as published by the Bureau of Labor and Statistics, for the period October through September. Subsequent annual cost changes will be made on a calendar year basis.

K. The cost effect of changes in occupancy levels based on average occupancy for the last three months of the fiscal period covered by the historical cost portion of the welfare per diem rate. This provision is applicable only to the first two fiscal years of newly constructed or newly established facilities. Welfare rates in subsequent fiscal periods will be based on the occupancy from the most recently completed fiscal year.

L. An unidentified cost change computed by multiplying the allowable historical costs from the most recently completed fiscal year less those costs relating to line–item costs for which there has been a cost projection times the percentage change in the Consumer Price Index in Minneapolis–Saint Paul as published by the Bureau of Labor and Statistics for the period October through September. In no case may the cost change be applied against the historical cost of salaries, changes in facilities or equipment, payroll–related costs, property taxes, interest, depreciation expense, rental payments, or raw food costs.

Cost changes determined under this provision must be based upon facts and commitments in existence as of the filing date of the report. If the provider cannot substantiate the fact that such facts and written commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to parts 9510.0550 and 9510.0590, subpart 9. If the sum of known cost changes calculated under items A to I do not in fact occur, the welfare rate will similarly be subject to adjustment under part 9510.0550. If the sum of actual cost increases exceed the known cost changes determined under A to L, no adjustment in welfare rate will be made.

Subp. 4. **Government grants for operations during prospective rate period.** Government grants for operations during the prospective rate period must be deducted from the welfare per diem rate either calculated in subparts 1, 2, and 3, or elected in part 9510.0560.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 654 art 5 s 58*

9510.0530 EFFECTIVE DATE.

A new per diem rate determined by the department will be effective the first day of the month following the provider's normal fiscal year–end except in instances in which penalty provisions of parts 9510.0590 and 9510.0880, item B are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days after the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0540 NOTIFICATION OF RATE DECISION.

A temporary rate notification consisting of the previous year's allowed historical cost per resident day plus 80 percent of the indicated allowed known cost changes per resident day will be issued and paid on receipt of the report. The commissioner will notify the provider, in writing, and the respective local social services agencies of the rate determined under these rules as well as the effective date of such rate. Included in this notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1994 c 631 s 31*

9510.0550 ADJUSTMENT FOR ERROR OR OMISSIONS.

All rates determined according to parts 9510.0500 to 9510.0890 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by part 9510.0590, subpart 9. Such adjustments are limited to the three complete fiscal years preceding the date on which an audit commences. If the adjustment results in a payment from the provider, payment shall be made by the provider within 120 days after the date on which the provider received written notification of the adjustment. If the adjustment results in a payment to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0560 SPECIAL RATE-SETTING PROCEDURES FOR NEW FACILITIES.

Subpart 1. **Required reports.** Providers with newly constructed or established facilities can request an interim welfare rate. The provider must submit reports as required in part 9510.0520, subpart 1 for immediate future fiscal year forecast results.

Subp. 2. **Report compliance.** Reports will comply with all applicable parts of these rules governing cost finding, reporting, and allowable costs, to the extent feasible in the individual circumstance. Noncompliance with any provision of these rules must be so stated, together with the reasons why the provider cannot comply.

Subp. 3. **Interim rate establishment.** The commissioner will establish an interim rate in accordance with part 9510.0520 retroactive to the first day on which a medical assistance recipient is placed in the home. Such rate shall be subject to retroactive upward or downward adjustment in accordance with all provisions of part 9510.0520, subpart 2 on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with parts 9510.0520, subpart 1 and 9510.0590, subpart 10. Such rate shall be subject to retroactive upward or downward adjustment based on occupancy of no less than 80 percent. The 80 percent occupancy factor shall apply only to facilities of more than ten beds. Adjustments to the interim rate may be made at the option of the provider either at the end of the provider's first fiscal year or after six months of historical cost experience. The settlement must be based on at least six months of historical cost and statistical experience. Occupancy for the immediate fiscal year must be based on an annualization of the last three months of the interim fiscal year but not less than 90 percent occupancy. Rate settlement requests which are in excess of the interim rates shall be subject to cost category ceilings according to parts 9510.0660 to 9510.0740.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0570 RATE LIMITATIONS.

Subpart 1. **Limitations based on private pay rates or relevant federal or state laws and regulations.** Notwithstanding any other provisions of these rules, the established provider rates for residential service will not exceed the normal provider's rate charged private residents for comparable residential services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited by federal laws or regulations that affect the medical assistance program. Rates charged for respite beds must be identified as a private pay rate.

Subp. 2. **Overall limitation.** Welfare rates will be limited to a 15 percent increase over the previous welfare rate. The 15 percent limitation does not apply to the following cost changes identified under part 9510.0520, subpart 3:

A. Salaries and payroll-related costs for additional personnel, depreciation, and interest expense for physical plant improvements or other fixed assets, and changes in licensed capacity insofar as these cost changes are incurred to meet minimum and immediate requirements imposed by federal, state, or local laws and regulations.

B. Salary cost changes which exceed 15 percent of the historical salaries if the salary cost changes are reasonable and are required to bring facility salaries to the salary range of comparable facilities. The salary cost changes for top management compensation, the administrator, and additional personnel are excluded from this exception.

C. Facilities that have a noncalendar year end and have been previously subject to the rate limitation may adjust the rates to the new rate limitation if previously justified by the reports.

D. The rate limitation will not apply to providers whose welfare rate request does not exceed 80 percent of the statewide weighted average rate determined annually on a calendar year basis utilizing the most recently completed fiscal year cost reports submitted on or before December 31.

E. The overall rate limitation will be computed by dividing total allowable cost by the actual resident days.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0580 APPEAL PROCEDURES.

Subpart 1. **Scope of appeals procedures.** These procedures describe the manner by which unresolved individual provider or local social services agency disputes that may arise about application of these rules excluding this part will be settled. Unresolved disputes are defined as those disagreements that cannot be resolved informally between the provider and the department staff normally assigned responsibility for administration, or the provider and a local social services agency.

Subp. 2. **Appeals examiner.** Unresolved disputes will be heard by a staff person from the state Office of Administrative Hearings.

Subp. 3. **Time limit.** The provider, or the county, has 30 days to appeal from the date of the department's notification of the new per diem rate.

Subp. 4. **Appeal procedure.** If the provider and the department's staff normally assigned responsibility for administration or the provider and a local social services agency cannot agree to a settlement of the dispute, then each party will submit in writing the facts, arguments, and any other appropriate data to the administrative law judge. The administrative law judge will review the dispute, request additional information or analyses to be submitted by the department or the provider, and then recommend to the commissioner disposition of the dispute. Because existing state law does not permit the commissioner to delegate powers, final authority on disposition of disputes must be retained by the commissioner.

Subp. 5. **Effective date of resolved disputes.** If the dispute is related to a change in the provider's rate, the amount in dispute will not be adjusted until final determination according to these appeal procedures is made. The total dollar amount due the provider or the program resulting from the resolved disputes will be subject to the payment provision of part 9510.0550.

Subp. 6. **Findings and conclusions.** Any findings, conclusions, or opinions of the administrative law judge about any appeal will be made available to the provider and will become part of the department record.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 640 s 32; 17 SR 1279; L 1994 c 631 s 31*

9510.0590 GENERAL REPORTING REQUIREMENTS AND SUBMITTAL PROCEDURES.

Subpart 1. **Required reports.** Except as provided by part 9510.0560 to receive a per diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the department. Reports, supporting documentation, and worksheets will consist of the following:

A. general provider information and statistical data;

B. financial statements consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations;

C. reports of historical costs and known changes together with supporting calculations and worksheets;

D. rate determination worksheets; and

E. all other data relevant to justification or support of the welfare rate as deemed necessary by the commissioner or designated representative.

Specific report formats and preparation instructions will be contained in a provider manual prepared and revised periodically by department personnel. Copies of said manual will be made available to all interested parties through the Print Communications Division of the Department of Administration. Newly established providers or providers who change their fiscal year must file short–period reports if the period covered is more than five months. Providers who have major program changes approved by the Department of Human Services may submit an amended report to show the change in costs due to the program change. The cost effect of the program change must be at least $2,000 for the remainder of the provider's reporting period in order for the provider to submit an amended report.

Subp. 2. **Method of accounting.** The accrual basis of accounting in accordance with generally accepted accounting principles shall be the only method acceptable for purposes of satisfying reporting requirements. In a unique situation such as the use of government providers, the use of the accrual basis of accounting may not be applicable. In such an instance, the commissioner may permit the provider to use a cash or modified cash basis of accounting if the provider can establish that no difference in rate would result.

Subp. 3. **Records.** The provider, where applicable, will maintain statistical and accounting records to support information in no less detail than that required by subpart 1 required reports. The provider shall also make available federal and state income tax returns upon request of department personnel.

Subp. 4. **Report certification.** Reports required in subpart 1 will be accompanied by a certification of the majority owner defined as the person having over 50 percent effective ownership, or the chief financial officer if there is no majority owner, and the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.

If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitted as a part of reports required by subpart 1.

Subp. 5. **Reporting deadlines and extensions.** Required reports shall be submitted directly to the department within three calendar months after the close of the provider's normal fiscal year.

The commissioner may grant exceptions to the reporting deadline for just cause. A routine extension of 60 days will be granted when a written request is received by the department prior to the reporting deadline.

Subp. 6. **Penalties.** Penalties include:

A. Report preparation and submittal. The penalty for noncompliance with subparts 1 and 5 will be to reduce the reimbursement rate to 80 percent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the commissioner.

B. False reports. Incorrect or false information supplied by the provider on required reports resulting in overpayments to the provider will result in one or more of the following:

(1) immediate adjustment of the welfare rate, along with retroactive recovery of funds incorrectly paid to the provider;

(2) termination of the provider contractual agreement; and

(3) prosecution under applicable federal and Minnesota statutes.

Subp. 7. **Audits.** All reports will be subjected to desk audit and may be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider recordkeeping and accounting practices, the commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of item A or B may be applied to ensure compliance with this provision.

Subp. 8. **Application of reasonable cost principles.** Reports required by subpart 1 must be prepared in accordance with reasonable cost principles in parts 9510.0660 to 9510.0870.

Subp. 9. **Amended reports.** Providers may file amendments to previously filed reports when mathematical errors or omissions are uncovered or when federal or state minimum wage law changes occur unexpectedly. The cost changes to comply with minimum wage laws will be limited to the wage increases required to meet the minimum standards of federal or state wage laws. Such changes in the welfare per diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less for each annual period.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 654 art 5 s 58; 17 SR 1279*

9510.0600 SPECIAL PROVISIONS FOR MULTIHOME PROVIDERS AND PROVIDERS INVOLVED IN OTHER BUSINESS ACTIVITIES.

Subpart 1. **Charges from related organizations.** Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. If the related organization in the normal course of business sells services, facilities, or supplies to the outsiders, the cost to the provider shall not be greater than the outsider's price; however, sales to outsiders must constitute at least 25 percent of its sales.

Subp. 2. **Cost allocation of top management salaries and management fees.** The allocated portion of compensation for the chair of the board, directors, presidents, or other similarly titled individuals and other corporate charges or costs allocated to a facility must represent the cost of services actually rendered and be identified according to the type of service provided.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *17 SR 1279*

9510.0610 COST CATEGORIES.

Costs used for rate–setting purposes and related to resident care are to be grouped according to major cost categories used in required reports. Such categories are defined as follows:

A. Resident–living: all directly identifiable personnel costs associated with residential service. Personnel costs to be included are the salaries of the director of residential living, supervisors of residential–living staff, and residential–living staff.

B. Developmental services: all directly identifiable costs of developmental services, such as training, rehabilitation, and social services not separately reimbursed according to item J.

C. Health services: all directly identifiable costs related to health services not separately reimbursed according to item J. Costs will include personnel, purchased services, and supplies.

D. Resident–related services: all directly identifiable costs of resident–related services, such as recreation, religion, arts and crafts, and leisure time activities not separately reimbursed according to item J. Costs will include personnel, purchased services, and supplies.

E. Food services: all directly identifiable costs of normal and special diet food, including food preparation and serving. Personnel costs to be included in dietary costs are the salaries of dietitians, chefs, cooks, dishwashers, and all other employees assigned to the kitchen and dining room.

F. Laundry and linen: all directly identifiable costs of linen and bedding, laundering, and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, sewing workers, launderers, and ironers.

G. Housekeeping: all directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, domestics, and other cleaning personnel.

H. Plant operation and maintenance: all directly identifiable costs for maintenance and operation of the buildings and grounds, including fuel, electricity, water, supplies, and

parts to repair and maintain equipment and facilities, and tools. Personnel costs to be included are the salaries of engineers, painters, heating plant employees, plumbers, electricians, carpenters, and security personnel.

I. General and administration: all directly identifiable costs for administering overall activities of the facility, including business–office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefits costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified in this part.

J. Miscellaneous nonreimbursable services and expenses:

(1) All directly identifiable costs of functions normally reimbursed by charges to residents, employees, or outsiders, such as the operating costs of a pharmacy, beauty shop, or coffee and gift shop, are included here.

(2) Also included are specific costs that may be incurred by the provider and reimbursed separately according to a fee schedule. These include but are not limited to the following: services provided by licensed medical, therapeutic, or rehabilitative practitioners; oxygen at prevailing prices; and wheelchair alterations for specific medical assistance recipients.

(3) Also included in this part will be costs associated with operating activities financed by restricted or unrestricted gifts or grants from private or public funds. Costs deemed unallowable under this part can be identified as offsets from such gifts or grants.

(4) All costs classified in item J are not allowable for purposes of determining a per diem rate under parts 9510.0500 to 9510.0890.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *17 SR 1279*

9510.0620 RESIDENT DAYS; DEFINITION.

For purposes of determining a per diem rate, a resident day is defined as a day for which full and normal billings were rendered.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0630 GENERAL COST–ALLOCATION PROCEDURES FOR ALL PROVIDERS.

Subpart 1. **Classification.** Costs will be classified in accordance with categories defined in part 9510.0610. Classification of costs to cost categories in part 9510.0610 will involve one or more of the following steps:

A. Direct identification, without allocation, which will be accomplished in the routine classification of transactions when costs are recorded in the books and records of the provider.

B. Other costs that cannot be classified to cost categories through use of the procedure in item A will be classified in the administrative category.

Subp. 2. **Adjustments for costs otherwise reimbursed.** Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in part 9510.0610, item J.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0640 ALLOCATION OF NONALLOWABLE PERSONAL EXPENSES FOR OWNERS LIVING IN THE FACILITY.

Allocation procedures are defined in the following items and must be applied in the order stated for personal expense included in the expenses of the facility.

A. Food services:

(1) cost allocation based on the number of meals served; and

(2) cost allocation based on actual resident days.

B. Laundry and linen, housekeeping, and plant operations and maintenance: cost allocation based on actual resident days.

C. Depreciation, interest, and real estate and personal property taxes:

(1) allocation based on the ratio of square feet of floor space devoted to personal use; and

(2) cost allocation based on actual resident days.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0650 ALLOCATION OF COSTS FOR PROVIDERS OF CARE OTHER THAN MENTALLY RETARDED SERVICES OR NURSING HOMES.

Reasonable cost allocations must be made for costs associated with care other than mentally retarded services or nursing home.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0660 REASONABLE COSTS.

Costs to be allowable for rate–setting purposes must satisfy the following overall criteria:

A. they must be necessary and ordinary costs related to resident care; and

B. they must be costs that prudent and cost–conscious management would pay for a given item or service.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0670 COSTS NOT ALLOWABLE.

Costs that relate to management inefficiency, unnecessary care or facilities, and activities not related to the mentally retarded field are not allowable.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0680 REASONABLE COMPENSATION.

Reasonable compensation of individuals employed in the facility is an allowable cost, provided that the services are actually performed in a necessary function and the costs reported are actually incurred. To be reasonable the compensation allowance must be such an amount as would ordinarily be paid for comparable services by comparable facilities. To be necessary the function must be such that had the individual not rendered the services, the facility would have had to employ another person to perform the services. The function must also be pertinent to the operation and conduct of the facility. Where the services are rendered on less than a full–time basis, the allowable compensation should reflect an amount proportionate to a full–time basis. Compensation shall include payment to individuals as well as to organizations of nonpaid workers that have arrangements with the provider for the performance of services by nonpaid workers.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0690 SUBSTANCE PREVAILS OVER FORM.

The cost effect of transactions that are conceived for the purpose of circumventing the rules contained in parts 9510.0500 to 9510.0890 will be disallowed under the principle that the substance of the transaction shall prevail over form.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0700 COSTS DUE TO CHANGES IN FEDERAL OR STATE REQUIREMENTS.

Costs incurred to comply with changes in federal or state laws and regulations on increased care and improved facilities are allowable costs for purposes of determining a historical per diem rate under part 9510.0520, subpart 1.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0710 REDUCTION IN COSTS.

Purchase discounts, allowances, and refunds are a reduction of the cost of whatever was purchased.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0720 ANNUAL REVIEW OF COST LIMITATIONS.

The commissioner shall review annually the depreciation basis limitation (part 9510.0770) and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0730 APPLICATION OF PRINCIPLES AND SPECIFIC LIMITS.

The reasonable cost principles defined in parts 9510.0660 to 9510.0740 apply to all reported costs and have been specifically defined for certain cost elements in parts 9510.0750 to 9510.0870.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0740 TOP MANAGEMENT COMPENSATION LIMITATION.

Top management compensation includes that of administrators, board of directors, and all other individuals receiving compensation as executives. The compensation must also be justified under part 9510.0680. The annual compensation will be determined according to the total number of licensed beds per facility as follows:

Number of beds	Cumulative annual bed compensation
1–30	$435
31–60	240
Over 60	180

For facilities of 30 beds or less the administrator's salary may be allocated between varied functions performed by the administrator if justified through review of personnel complement by licensing personnel. A top management individual who is compensated in more than two facilities with a total bed complement of more than 50 beds shall be subject to the compensation limitation on a cumulative basis of all facilities served by the individual. The maximum compensation limitation shall be $35,000 per facility.

For each full percentage point increase in the Consumer Price Index in Minneapolis–Saint Paul as published by the Bureau of Labor Statistics for the month of October 1974 and October 1975, new series index (1967 = 100), the annual compensation limitation shall be increased by one percent. The increase, if any, generated by this formula shall be affected on January 1, 1976. Similar calculations shall be made for each successive year using the October indices for two successive years with the increases beginning effective the following January.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0750 GENERAL AND ADMINISTRATIVE EXPENSES.

Subpart 1. **In general.** Reasonable cost criteria for general and administrative expenses are as follows.

Subp. 2. **Owners life insurance.** The costs of premiums are not allowable.

Subp. 3. **Personal expenses.** Personal expenses of owners or employees such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation are reasonable.

Subp. 4. **Professional, technical, or business–related organizations.** These costs are allowable if their function and purposes can be reasonably related to the development and operation of facilities and programs for the rendering of resident–care services.

Subp. 5. **Social, fraternal, and other organizations.** Costs incurred in connection with memberships in all organizations not included in subpart 4 are not allowable.

Subp. 6. **Travel and automobile.** These expenses are not an allowable expense unless they are related to activities of managing the facility.

Subp. 7. **Entertainment.** These expenses are not allowable costs.

Subp. 8. **Advertising.** Costs incurred in connection with maintaining or maximizing occupancy are allowable.

Subp. 9. **Pension plans and profit sharing.** Contributions to either an Internal Revenue Service–approved pension or profit–sharing plan, but not both, are allowable costs.

Subp. 10. **Employee education costs, orientation, and on–the–job training.** Costs relating to providing improved resident care or, where required by state law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories in part 9510.0610 unless not identifiable.

Subp. 11. **Training programs for nonemployees.** Costs of training programs conducted for nonemployees other than for volunteers are not allowable.

Subp. 12. **Telephone, television, and radio service.** These are allowable costs where furnished to the general resident population in areas of the living unit, recreation rooms, lounges, etc. The costs of these services when located in a resident's private accommodation are not allowable.

Subp. 13. **Noncompetitive agreement.** Costs of these agreements are not allowable.

Subp. 14. **Preopening costs.** One–time preopening costs of new facilities incurred prior to admittance of residents must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period of no less than 60 consecutive months beginning with the month in which the first resident is admitted for care. Examples of these costs are wages paid for services rendered more than 30 days prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.

Subp. 15. **Bad debts.** Amounts considered to be uncollectible resident accounts are not allowable costs.

Subp. 16. **Fundraising costs.** Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by part 9510.0850.

Subp. 17. **Charitable contributions.** These are not allowable costs.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0760 DEPRECIATION; BASIS FOR CALCULATION.

Subpart 1. **Cost.** Historical cost of facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by subpart 2.

Subp. 2. **Change in ownership of facilities.** In a case in which a change in ownership of a facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:

A. In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of:

(1) the portion of the purchase price properly allocable to depreciable facilities; or

(2) the appraised value of the depreciable facilities calculated under the reproduction–cost–depreciated method.

B. In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to item A, the case of a complete change in ownership, except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 percent. Any increase allowed by this part will then be adjusted according to subpart 6.

Subp. 3. **Redemption of ownership interests.** In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying subpart 2, item B.

Subp. 4. **Donated assets.** The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price that an able buyer

would pay a willing seller in an arms length sale or appraised value defined in subpart 2, item A, subitem (2) whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or the services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

Subp. 5. **Subsequent acquisitions.** The basis for calculating depreciation may be increased for the actual cost of equipment additions or facility modification or renovation.

Subp. 6. **Recapture of depreciation resulting from sale of facility.** The sale of depreciable property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture will be determined as follows:

A. The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after the effective date of parts 9510.0500 to 9510.0890.

B. The gross recapture amount as determined in item A shall be allocated to fiscal periods from the effective date of parts 9510.0500 to 9510.0890 through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under parts 9510.0500 to 9510.0890. The amount allocated to each period shall be divided by the total actual resident days in that period, thereby determining a resident day cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the resident–day cost for each fiscal period.

C. The total net recapture amount determined according to item B will be reduced by one percent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the state of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of subpart 2.

The net recapture amount so determined in item C will be paid by the new owner to the state of Minnesota within a time period agreed to by the commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

Subp. 7. **Gains and losses on disposition of equipment.** Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these rules. Gains or losses on trade–ins should be reflected in the asset basis of the acquired asset. Abandonment losses will be limited to five cents per resident day annually; however, any excess over this limitation can be carried forward to future years.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0770 DEPRECIATION LIMITATIONS.

A. The total basis of depreciable facility assets shall not exceed an average of $25,194 per bed for Class A beds and $29,452 per bed for Class B beds built or purchased after December 31, 1979. This limitation will be adjusted annually beginning January 1, 1981, according to a construction index as determined by the commissioner.

B. In no instance can accumulated depreciation calculated in accordance with part 9510.0760 to 9510.0830 exceed the basis defined in part 9510.0760.

C. Accumulated depreciation as of the beginning of the first fiscal year covered by this part shall be calculated retroactively using the useful lives defined in parts 9510.0780 and 9510.0790.

D. Regardless of the applicability of the limitation stated in item A, depreciation on investments in facility modifications and new equipment will be allowed if they were required by local, state, or federal requirements. After the facility's first three complete fiscal years and every three years thereafter, the facility's investment per bed limitation will be adjusted to reflect the average annual increase for equipment additions and/or facility modification. The investment per bed revision does not apply to original construction and/or investment costs. The investment per bed revision will not be an exception to the overall maximum of part 9510.0570, subpart 2. The change in the investment per bed limitation will be

based on the Consumer Price Index for housing in Minneapolis–Saint Paul as published by the Bureau of Labor and Statistics for the period October through September.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0780 DEPRECIATION RATES FOR NEW FACILITIES AND EQUIPMENT.

Depreciation shall be calculated using the basis determined under part 9510.0760, applying the following useful life schedule:

A. building, 35 years;

B. building improvements, depreciated over the remaining life of the principal asset or useful life, but not less than 15 years;

C. land improvements, 20 years;

D. equipment, five years; and

E. vehicle, four years.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0790 OTHER USEFUL LIVES.

Subpart 1. **Depreciation rates for used facilities and equipment.** The useful life shall be assigned by the provider, considering the individual circumstances; however, the useful life will not be shorter than one–half of the useful life provided by part 9510.0780.

Subp. 2. **Leasehold improvements.** The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0800 DEPRECIATION METHOD.

The straight–line method of depreciation should be used except, at the option of the provider, when the principal payments on capital indebtedness exceed the total depreciation allowance calculated in accordance with parts 9510.0760 to 9510.0830. In such an instance, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and five years for equipment. Accumulated depreciation cannot exceed the basis defined in part 9510.0760.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0810 FACILITIES FINANCED BY PUBLIC FUNDS.

Depreciation will not be allowed on the portion of facilities financed by federal, state, or local appropriations or grants unless the intent of such appropriation or grant was that it be repaid through operating revenue of the facility.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0820 NONDEPRECIABLE ASSETS.

Facility assets that are not depreciable include but are not restricted to land, including the land owned and used in provider operations. Included in the cost of land are the costs of permanent roadways and grading of a nondepreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of nondepreciable nature.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0830 CAPITALIZATION VS. EXPENSE.

Expenditures for equipment that has a useful life of more than one year shall be capitalized except that the provider may show as expenses small equipment purchases normally capitalized if such items do not exceed five cents per resident day annually.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0840 LEASED FACILITIES OR EQUIPMENT.

Subpart 1. **Rental charges.** Rental charges incurred by a provider through reasonable bona fide leases between unrelated parties are includable in allowable costs unless:

A. Rental charges result from a sale, lease–back arrangement, or lease with option to buy at a price less than anticipated value.

B. Rental charges are paid to a related or controlled organization. If either item A or B exists, the provisions of item B will be applied.

Subp. 2. **Allowable costs in lieu of disallowed rental charges.** If rental charges are not allowed, the provider will be allowed depreciation computed in accordance with parts 9510.0760 to 9510.0830 as if the disallowed transaction had not occurred. In addition, the provider will be allowed the reasonable cost of the facility assumed by the lessor such as interest on capital indebtedness up to 65 percent of net allowable assets, taxes, insurance, other costs, and earnings allowance provided by parts 9510.0860 and 9510.0870, if applicable.

Subp. 3. **Limitation.** Allowable rental charges are subject to the investment per bed limitations of part 9510.0860, item A, determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of Federal Hospital Insurance Trust Fund obligations as of the effective date of the lease.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0850 COST OF CAPITAL.

Subpart 1. **Interest.** Interest expense is an allowable cost and will be classified as follows:

A. Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchased fixed assets related to providing residential care as defined in part 9510.0860, item A. The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

B. Other interest for working capital and operating needs that directly relate to providing residential care is an allowable cost. The form of indebtedness will include, but not be limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.

Subp. 2. **Interest income.** Interest income will be a deduction from interest allowable under subpart 1, item A or B. Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpended donated funds carried by the facility that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

Subp. 3. **Interest rate.** The interest rate incurred must not be in excess of what a borrower would have had to pay in an arms–length transaction in the money market when the loan was made. When a nonproprietary provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is allowable at a rate not to exceed the interest rate the fund is currently earning. Interest on loans between operating and building funds is not allowable.

Subp. 4. **Construction interest.** Interest cost incurred during and related to construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for resident care.

Subp. 5. **Allowable interest limitation for proprietary providers.** Because of part 9510.0860 for proprietary providers, the allowable interest expense defined in subpart 1, item A shall not exceed the provider's average interest rate times 65 percent of net allowable assets as defined in subpart 1, item A.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0860 EARNINGS ALLOWANCE FOR PROPRIETARY PROVIDERS.

An allowable cost for rate setting purposes is a reasonable return on capital provided by owners of proprietary facilities. The return will be applicable only to the portion of investment devoted to welfare recipients, and the return represents an earnings opportunity, not a guarantee. This return does not represent an attempt to regulate the actual return realized by proprietary providers. The earnings allowance will be determined individually for each provider, considering the following factors:

A. Net allowable fixed assets employed will include actual cost of land, land improvements, buildings, and equipment minus cumulative depreciation calculated in accordance with parts 9510.0760 to 9510.0830 and further limited to $1,000 in excess of the limitations provided in part 9510.0770, item A.

B. The amount of capital provided by owners will be assumed to be 35 percent of the net allowable fixed assets employed in providing residential care.

C. The after–tax rate of return allowed on capital provided by owners, calculated on the basis of items A and B, will be ten percent.

D. To obtain an after–tax rate of return of ten percent requires that the earnings allowance include an amount for average effective federal and Minnesota corporate income tax rates of 31.3 percent to 54.24 percent, depending upon the tax bracket that would result from applying the rate of return to net allowable fixed assets.

E. An additional earnings allowance will be allowed on the remaining 65 percent of net allowable fixed assets not otherwise covered by capital indebtedness. The allowance will be six percent of this amount.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0870 MINIMUM COST OF CAPITAL ALLOWANCE FOR PROVIDERS.

Notwithstanding the provisions of parts 9510.0850, subpart 5 and 9510.0860, the cost of capital allowance shall be no less than the combination of:

A. actual interest on capital indebtedness; and

B. an earnings amount determined by multiplying resident days for a fiscal year, or part thereof if a short period report is being filed, by 35 cents.

The minimum cost of capital allowance will be adjusted annually on a calendar year basis according to the Consumer Price Index for all items in Minneapolis–Saint Paul as published by the Bureau of Labor Statistics for the period October through September. The initial revised minimum cost of capital allowance will be 58 cents.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0880 EFFECTIVE DATE OF REVISIONS.

All revisions of parts 9510.0500 to 9510.0890 shall be effective January 1, 1981 for cost reports submitted for fiscal years ended after December 31, 1979.

Providers may request by letter, no later than March 31, 1977, a revised rate as affected only by part 9510.0570, subpart 2. The revised rate may be effective as of January 1, 1977.

Statutory Authority: *MS s 256B.27; 256B.50*

9510.0890 SEVERABILITY.

If any provisions of parts 9510.0500 to 9510.0890 as adopted by the commissioner of human services are found through judicial procedures to be invalid, the remaining provisions shall remain valid.

Statutory Authority: *MS s 256B.27; 256B.50*

History: *L 1984 c 654 art 5 s 58*

HEALTH CARE FACILITY REPORTS

9510.1000 STATUTORY AUTHORITY AND PURPOSE.

Parts 9510.1000 and 9510.1010 are enacted pursuant to Laws of Minnesota 1973, chapter 688, section 8, in order to provide a system for the financial reporting of all facilities licensed under provisions of Minnesota Statutes, sections 144.50 to 144.58.

Statutory Authority: *MS s 256B.30*

9510.1010 REQUIRED HEALTH CARE FACILITY REPORTS.

All facilities except those filing reports pursuant to parts 9510.0010 to 9510.0890, licensed under the provisions of Minnesota Statutes, sections 144.50 to 144.58, must file the following information with the commissioner of the Department of Human Services within 90 days of the end of the facility's normal fiscal year:

A. an annual statement of income and expenditures;

B. a complete statement of all fees and all charges; and

C. the names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

Statutory Authority: *MS s 256B.30*

History: *L 1984 c 654 art 5 s 58*

SPECIAL NEEDS RATE EXCEPTION FOR VERY DEPENDENT PERSONS WITH SPECIAL NEEDS

9510.1020 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9510.1020 to 9510.1140 have the meanings given them in this part.

Subp. 2. **Case manager.** "Case manager" has the meaning given it in part 9525.0004, subpart 4.

Subp. 3. **Client.** "Client" means a person who is receiving training and habilitation services or intermediate care facility for the mentally retarded services funded under the medical assistance program.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or a designated representative.

Subp. 5. **County.** "County" means the county board of commissioners for the county which provides case management services to the client or the county board of commissioners' designated representative.

Subp. 6. **Degenerative disease.** "Degenerative disease" means a category of neurological impairment such as Hurler's syndrome, tuberous sclerosis, Alzheimer's disease, or Huntington's chorea with a disorganization of motor function or chronic brain syndrome.

Subp. 7. **Employee benefits.** "Employee benefits" means compensation actually paid to or for the benefit of the employees other than salary. Employee benefits include group health or dental insurance, group life insurance, pensions or profit sharing plans, governmentally required retirement plans, sick leave, vacations, and in kind benefits. Employee benefits do not include payroll–related costs.

Subp. 8. **Equipment.** "Equipment" means aids designed to increase a client's ability to live and function independently which are purchased for the client, remain the property of the client and can be moved with the client upon discharge.

Subp. 9. **Intermediate care facility for the mentally retarded or ICF/MR.** "Intermediate care facility for the mentally retarded" or "ICF/MR" means a program licensed to serve residents having mental retardation or related conditions under Minnesota Statutes, section 252.28, and a physical plant licensed as a supervised living facility under Minnesota Statutes, chapter 144, which together are certified by the Minnesota Department of Health as an intermediate care facility for the mentally retarded.

Subp. 10. **Medical review team.** "Medical review team" means a group of physicians and social workers who are under contract with the Department of Human Services to review a medical and social history for the purpose of determining a person's disability within the scope of the regulations of the Social Security Administration.

Subp. 11. **Provider.** "Provider" means the person or entity operating a licensed training and habilitation service or an ICF/MR.

Subp. 12. **Payroll–related costs.** "Payroll–related costs" means the employer's share of social security withholding taxes, workers' compensation insurance or actual cost if self insured, and state and federal unemployment compensation taxes or costs.

Subp. 13. **Special needs rate exception payment.** "Special needs rate exception payment" means a payment established under parts 9510.1020 to 9510.1140.

Subp. 14. **Staff intervention.** "Staff intervention" means the direct client care provided by program personnel or outside program consultants, or the training of direct care program personnel by outside program consultants for the purpose of addressing the client's needs as identified in the special needs rate exception application.

Subp. 15. **Regional treatment center.** "Regional treatment center" means an ICF/MR or nursing home owned and operated by the state of Minnesota.

Subp. 16. **Training and habilitation services.** "Training and habilitation services" means health and social services provided under Minnesota Statutes, sections 252.40 to 252.47. For purposes of parts 9510.1020 to 9510.1140, training and habilitation services do not include training and habilitation services provided as a waivered service as defined in Minnesota Statutes, section 256B.501, subdivision 1, and parts 9525.1800 to 9525.1930.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354; 18 SR 2244*

9510.1030 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** Parts 9510.1020 to 9510.1140 establish procedures for counties and providers to follow to seek authorization for a special needs rate exception for very dependent persons with special needs and establish procedures for determining the special needs rate exception payments for training and habilitation services and for intermediate care facilities for the mentally retarded. Parts 9510.1020 to 9510.1140 do not apply to persons with mental retardation or related conditions who reside in a regional treatment center.

Subp. 2. **Purpose.** The purpose of the special needs rate exception is to provide to a specific client those staff interventions or equipment whose costs are not included in the per diem rate of the intermediate care facility for the mentally retarded or the per diem rate of the training and habilitation service. The special needs rate exception payment is intended to fund short–term special needs for a specific client in order to prevent the placement or retention of the client in a regional treatment center. The special needs rate exception is only to be allowed after all other funding sources or alternatives have been exhausted.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1040 APPLICATION TO BE COMPLETED BY PROVIDER.

Subpart 1. **Application.** The provider shall apply to the county for a special needs rate exception to cover the cost of a staff intervention or piece of equipment necessary to serve clients eligible under part 9510.1050, subpart 2. A separate application must be completed for each client unless the staff intervention or equipment is shared by the clients identified. If more than one client is included in the application, client information must be submitted for each client. The application must include the information in subparts 2 to 4.

Subp. 2. **Information about client's needs and methods used to address needs.** The provider shall:

A. identify the client including:

(1) name;

(2) name and address of the client's legal representative;

(3) medical assistance identification number;

(4) date of admission or anticipated admission to the provider's program;

(5) diagnosis;

(6) age;

(7) current residence; and

(8) current day program;

B. describe the client's special need or needs which put the client at risk of regional treatment center placement or continued regional treatment center placement;

C. describe the proposed staff intervention including:

(1) the amount of staff or consultant time required;

(2) qualifications of the program staff or outside consultants providing the intervention;

(3) type of intervention;

(4) frequency of intervention;

(5) intensity of intervention; and

(6) duration of intervention;

D. describe the equipment needed and the plan for use of the equipment by the client;

E. identify the total cost and the unit cost of the equipment or the staff intervention;

F. describe the modifications needed to integrate the equipment and staff intervention into the client's individual program plan;

G. describe the projected behavioral outcomes of the staff intervention or the use of the equipment and when the outcomes will be achieved;

H. describe how the client's progress toward the behavioral outcomes in item G will be measured and monitored by the provider; and

I. describe the degree of family involvement with the client.

Subp. 3. **Information about provider.** The provider shall submit:

A. information identifying the provider including:

(1) name and address of the provider;

(2) name and address of the place where the staff intervention and equipment will be delivered, if different from subitem (1);

(3) name and telephone number of the person authorized to answer questions about the application; and

(4) medical assistance provider number; and

B. and explanation of the efforts used to meet the client's needs within the provider's current per diem rate, including:

(1) modifications made to the individual program plan;

(2) reallocation of current program personnel;

(3) training and in–service provided to program personnel for the year immediately preceding the date of the provider's application to the county; and

(4) other available resources used.

Subp. 4. **Supporting documentation.** The provider shall submit with the application the following:

A. A copy of the individual program plan including the measurable behavioral outcomes which are anticipated to be achieved by the client as a result of the proposed staff intervention or the equipment.

B. Documentation of the provider's historical costs on which the current per diem rate is based. An ICF/MR provider shall submit a copy of the most recent rate determination letter. A training and habilitation service program shall submit a copy of its current budget, year–to–date expenses, and current assets.

C. Work papers showing the method used to determine the cost of the staff intervention and equipment identified in subpart 2, item E, including the hourly wage of staff who will implement the intervention, the unit cost of consultation or training services, and the unit cost of equipment requested.

D. Documentation that any equipment requested in the application is not available from the Department of Vocational Rehabilitation or covered under parts 9505.0170 to 9505.0475.

E. Documentation that any consultant services requested in the application are not services covered under parts 9505.0170 to 9505.0475.

F. The name and address of any vendor or contractor to be reimbursed by the special needs rate exception and the name of the person or persons who will actually provide the equipment or services if known.

G. A plan to decrease the client's reliance on the proposed staff intervention.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1050 COUNTY REVIEW OF PROVIDER'S APPLICATION.

Subpart 1. **Criteria.** The county shall determine if the provider submitting the application and the client or clients identified in the application meet the criteria in subparts 2 to 5.

The county shall submit to the commissioner the applications which meet the criteria in subparts 2 to 5.

Subp. 2. **Client eligibility.** A client shall be eligible for a special needs rate exception if the client meets the criteria in items A to D:

A. the client is eligible for medical assistance under Minnesota Statutes, chapter 256B;

B. the client is a resident of an ICF/MR;

C. the client is a person as defined in part 9525.0004, subpart 19, and has at least one of the following characteristics:

(1) severe maladaptive behavior as listed in unit (a), (b), or (c);

(a) self-injurious behavior which is a clear danger to the client such as ingesting inedibles; removing major items of clothing; striking, biting, or scratching self; moving into dangerous situations which clearly threaten or endanger the client's life, sensory abilities, limb mobility, brain functioning, physical appearance, or other major physical functions; or

(b) aggressive behaviors which are a clear danger to others such as striking, scratching, or biting others; throwing heavy objects at others; attempting inappropriate sexual activity with others; or pushing or placing others into dangerous situations which clearly threaten or endanger their life, sensory abilities, limb mobility, brain functioning, sexual integrity, physical appearance, or other major physical functions; or

(c) destructive behaviors which result in extensive property damage;

(2) severe physical disabilities such as deafness, blindness, or motor problems which require short-term environmental orientation training;

(3) medical conditions as listed in unit (a) or (b);

(a) degenerative diseases diagnosed by a physician as terminal; or

(b) short-term medical disabilities that can be treated within the level of care the Minnesota Department of Health certifies the ICF/MR to provide, such as temporary immobility, intermittent catheterization, or postoperative recuperation;

D. the client is at risk of placement in a regional treatment center within 60 days or of remaining in a regional treatment center, unless additional resources are provided through parts 9510.1020 to 9510.1140 due to:

(1) conditions and characteristics described in item C; and

(2) the unavailability of other resources as determined under subpart 4.

Subp. 3. **General provider eligibility.** A provider shall be eligible for a special needs rate exception if the provider meets the following criteria:

A. The existing program or services offered by the provider cannot be modified to meet the client's needs within the provider's approved per diem rates.

B. The provider's historical cost per diem does not include the historical cost of providing the same or similar clients with the same or similar staff interventions.

C. The provider is willing to serve or continue to serve a client who is eligible for a special needs rate under subpart 2 if the special needs rate exception is approved.

Subp. 4. **Availability of other resources.** The provider shall be eligible for a special needs rate exception only if the county determines that:

A. There are no other existing resources or services covered under parts 9505.0170 to 9505.0475 available to meet the client's needs.

B. There are no other appropriate ICFs/MR, training and habilitation services, or other services located within a reasonable distance available to meet the person's needs within their current rates. To determine if another ICF/MR, training and habilitation service, or other service is appropriate for the client, the case manager shall:

(1) Consider the placement preferences of the client and family of the client. If the client cannot communicate a preference, the client's legal representative must be consulted.

(2) Consider whether the location of the alternative ICF/MR training and habilitation service or other service will impair the current level of family involvement.

(3) Consider the length of time that the client will need the additional services.

Subp. 5. **Evaluation of staff intervention and equipment purchases.** The county shall review the information submitted in accordance with part 9510.1040 to determine if:

A. the proposed staff intervention and equipment are allowable for purposes of reimbursement under parts 9510.1020 to 9510.1140;

B. all proposed services and service providers comply with applicable professional and program licensure standards;

C. the proposed staff intervention and equipment purchases meet the identified client needs; and

D. the provider has included a plan to decrease the client's reliance on the proposed staff intervention which shall ensure integration of the client into the existing program when the special needs rate exception terminates.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354; 18 SR 2244*

9510.1060 COUNTY APPROVAL PROCESS.

Subpart 1. **Time period.** The county shall approve or deny applications within ten working days of the date the complete application was received from the provider. Approval or denial shall be made in accordance with subparts 2 to 4.

Subp. 2. **Consultation with county of financial responsibility.** If the county which receives the provider's application is not the county of financial responsibility, the county which receives the provider's application shall consult with the county of financial responsibility before approving the provider's application. The county of financial responsibility's statement of approval or objections must be forwarded to the commissioner with the provider's approved application or notice of denial. If the county of financial responsibility's statement of approval or objections are not forwarded to the commissioner, the county's application shall not be considered complete.

Subp. 3. **County approval or denial.** The county shall review the provider's application to determine if the application is complete and meets the criteria in 9510.1020 to 9510.1140. The county shall approve the provider's application if the application is complete and meets the criteria. The county shall deny the provider's application if the application is incomplete or does not meet the criteria unless the provider's application can be adjusted to meet the criteria or the county submits a written request for a variance under part 9510.1100.

Subp. 4. **Notification.** The county shall send the provider and the client written notice of the county's decision on the provider's application as soon as a decision is made or within ten working days after receipt of the application, whichever occurs first. If the county denies the provider's application, the county shall notify the commissioner, provider, client, and the client's legal representative of the reasons for the denial in writing. The notice of the denial must state the specific provisions of the provider's application on which the county based the denial.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1070 COUNTY'S APPLICATION TO COMMISSIONER.

If the county approves the provider's application, the county shall apply to the commissioner for a special needs rate exception within ten working days of the date of receipt by the county from the provider of a complete application and supporting documentation. To apply for a special needs rate exception, the county shall submit to the commissioner a copy of the provider's approved application and supporting documentation and the following documents:

A. documentation of the steps taken by the county to determine client and provider eligibility in accordance with parts 9510.1020 to 9510.1140, including documentation of the conditions which put the client at risk of regional treatment center placement or continued regional treatment center placement;

B. a copy of the client's current individual service plan which explains the need to place or retain the eligible client in a regional treatment center if the requested services can-

not be provided and the sections of the individual program plans which include the methodology and measurable outcomes of the proposed intervention;

C. a copy of the client's most recent medical evaluation signed by a physician;

D. a copy of the client's regional treatment center discharge plan, if the special needs rate exception is requested to facilitate the client's discharge from a regional treatment center;

E. a copy of the county's plan to coordinate and monitor the implementation of the proposed staff intervention described in the application submitted according to part 9510.1040;

F. a letter from the county of financial responsibility stating approval of the changes in the individual service plan if the county submitting the application is not the county of financial responsibility; or if the county of financial responsibility does not approve the changes, a letter stating the reasons the county of financial responsibility does not approve the changes and describing the actions, if any, to be taken by the county of financial responsibility; and

G. if the special needs rate exception is not requested for both the day training and habilitation service and the ICF/MR, a written explanation must be provided by the county.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 14 SR 2354; 18 SR 2244*

9510.1080 COMMISSIONER'S DETERMINATION.

The commissioner shall review the county application to determine if the requirements in parts 9510.1020 to 9510.1140 are satisfied in determining whether to approve or deny an application for a special needs rate exception. The commissioner shall notify the county, provider, the client, and the client's legal representative of the decision within ten working days of the date the commissioner receives a completed application from the county. The special needs rate exception, if approved by the commissioner, must be effective as of the date the county submits a completed application to the commissioner. If the commissioner denies the application, the commissioner shall notify the county, provider, and client or client's representative in writing of the reasons for the denial.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1090 ESTABLISHING SPECIAL NEEDS RATE EXCEPTION PAYMENT.

Subpart 1. **Established by commissioner.** The commissioner shall establish the special needs rate exception payment according to subparts 2 to 5.

Subp. 2. **Allowable costs.** Unless otherwise reimbursable by the Department of Vocational Rehabilitation or by direct payments under parts 9505.0170 to 9505.0475, the following costs, if approved by the commissioner in accordance with parts 9510.1020 to 9510.1140 and 9553.0010 to 9553.0080, are allowable for purposes of establishing the special needs rate exception payment:

A. additional salary, employee benefits, and payroll–related costs for direct care staff required to meet the client's needs as identified in the provider's application;

B. additional costs of services provided by a licensed medical, therapeutic, or rehabilitation practitioner; a mental health practitioner supervised by a board–certified psychiatrist; or a licensed psychologist or licensed consulting psychologist;

C. the costs of equipment required to meet the client's needs as identified in the provider's application.

Subp. 3. **Nonallowable costs.** Only costs listed in subpart 2 are allowable for purposes of establishing the special needs rate exception. All other costs shall be disallowed.

Subp. 4. **Limitation.** The combined per diem costs of training and habilitation services, ICF/MR services, and the special needs rate exception payment and any other special needs rate exception payments in effect for the same client, shall not exceed the medical assistance per diem cost of providing services to persons with mental retardation or related conditions in regional treatment centers. For the purpose of determining this limitation, items A to F apply.

A. The training and habilitation services per diem in effect on the date the provider's completed application is submitted to the county must be multiplied by the number of days the services are provided annually.

B. The ICF/MR's temporary or final payment rate in effect on the date the provider's completed application is submitted to the county must be multiplied by 365.

C. The special needs rate exception amount must not exceed the total of the costs allowable under subpart 2. If a special needs rate exception is necessary for a client in both the ICF/MR and the training and habilitation service program, the amounts of both special needs rate exceptions must be combined. If the client is currently receiving a special needs rate exception, that amount must also be included.

D. The amounts determined in items A to C must be combined and divided by 365 to determine the combined per diem cost.

E. The regional treatment center medical assistance per diem rate must be the rate in effect on the date the provider's completed application is submitted to the county.

F. If the per diem cost in item D exceeds the per diem cost in item E, the commissioner shall deny the special needs rate exception application unless the per diem cost can be adjusted to meet the client's needs within the per diem cost in item E or the commissioner grants a variance under part 9510.1100.

Subp. 5. **Computation of special needs rate exception payment.** The special needs rate exception payment must be calculated as follows:

A. The cost of additional equipment allowed in accordance with subpart 2, item C shall be paid as a lump sum payment during the first billing period following approval of the special needs rate exception.

B. Except as provided in item C, in order to compute the special needs rate exception payment for personnel costs, the costs of additional personnel allowable according to subpart 2, items A and B, must be divided by the estimated number of days the staff intervention will be needed.

C. In order to compute the special needs rate exception payment for personnel costs which vary during the estimated staff intervention period, the costs must be assigned on a monthly basis proportionate to the actual personnel costs incurred and then divided by the number of client days in the month.

D. Costs computed under items B and C shall be reimbursed as incurred and billed.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1100 VARIANCE REQUEST.

Subpart 1. **Variance request.** The county may request a variance from the commissioner to approve a provider application which exceeds the limit in part 9510.1090, subpart 4 by up to 15 percent, if the provider meets the criteria in subpart 2.

Subp. 2. **Eligible provider.** A licensed provider of training and habilitation services may apply for a variance if the provider is not an ICF/MR and provides or plans to provide training and habilitation services to a client who resides in an ICF/MR which has a per diem rate equal to or greater than 85 percent of the medical assistance per diem cost of providing services to persons with mental retardation or related conditions in the regional treatment centers.

Subp. 3. **Submittal of request.** The county shall submit the written variance request, including documentation showing that the provider meets the criteria for a variance, with the county's application for the special needs rate exception payment.

Subp. 4. **Review of variance request; notification.** The commissioner shall review the variance request with the county's application for the special needs rate exception payment. If the county's application meets all of the requirements in parts 9510.1020 to 9510.1140 except the limitation in part 9510.1090 subpart 4 and the provider is eligible to apply for a variance under subpart 2, the commissioner shall approve the request. If the commissioner denies the variance request, the commissioner shall notify the county, provider,

client, and the client's legal representative within ten days of receipt of the variance request of the reasons for the denial.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1110 EMERGENCY PROCEDURE.

Subpart 1. **Definition.** For the purposes of this part, an emergency is either:

A. a postoperative condition resulting from unplanned surgery or unanticipated complications resulting from planned surgery which would result in continued placement in a hospital or skilled nursing facility, loss of placement in a community ICF/MR, and admission to a regional treatment center within 60 days; or

B. the sudden onset of self–injurious or aggressive client behavior which results in an immediate danger to self or others; which would result in immediate admission to the regional treatment center in the absence of intervention.

Subp. 2. **Emergency approval.** In an emergency, the county may approve the addition of staff, consultation, or staff training necessary to intervene in the emergency without obtaining prior approval of a special needs rate exception from the commissioner if the county determines that all other client and provider eligibility is met. Only costs meeting the definitions under part 9510.1090, subpart 2, items A and B, shall be allowed under this part. No funds spent will be reimbursed, even in an emergency, without the county's approval. In an emergency, the county shall:

A. notify the commissioner by telephone no later than the next working day and in writing within three working days of the client's situation, and state in the notice a description of the behaviors or medical condition requiring emergency intervention and the actions taken by the provider to control the behaviors, and expenditures authorized by the case manager; and

B. complete and submit, according to parts 9510.1020 to 9510.1140, an application for a special needs rate exception for the emergency period and for any additional period, within 30 days of the date the county notified the commissioner of the emergency.

Subp. 3. **Reimbursement for emergency services.** A special needs rate exception for the costs identified in part 9510.1090, subpart 2, item A or B, approved in accordance with subpart 2 shall be reimbursable for a period not to exceed 30 days from the date the county notifies the commissioner of the emergency. No payment shall be authorized by the commissioner for services provided during an emergency until an application is submitted to the commissioner by the county delineating actual costs of the intervention. The total amount authorized for payment by the commissioner is subject to the per diem limitations under part 9510.1090, subpart 4.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1120 DURATION OF SPECIAL NEEDS RATE EXCEPTION.

Subpart 1. **Maximum length of time for a special needs rate exception.** A special needs rate exception for a staff intervention must be limited to one approval per eligible client for a period of time not to exceed one year from the date of receipt of the county application by the commissioner except as provided in subpart 2.

Subp. 2. **Renewals.** If the county determines that a special needs rate exception should be continued after the period initially approved, the county shall submit a new application in accordance with parts 9510.1020 to 9510.1140 at least 30 days prior to the date the special needs rate exception is scheduled to terminate. The county application for a renewal must contain a program and fiscal evaluation demonstrating the effectiveness of the initial special needs rate exception. A special needs rate exception for a staff intervention must be limited to two renewals, each of one year or less, per identified special need.

Subp. 3. **Terminations.** The commissioner may terminate the special needs rate exception prior to the date stated in the application upon recommendation by the county. The county may recommend termination if:

A. the rate is no longer necessary because other funds are available;

B. the rate is no longer necessary because a more appropriate residential or day training and habilitation placement is available;

C. there is evidence that the funds have not been used for the purposes stated in the application;

D. the client's needs have changed and can be met without the special needs rate exception; or

E. no progress has been made in rectifying the identified problem area. This item shall not apply to services provided to clients with degenerative diseases if the criteria in subitems (1) to (4) are met:

(1) the service is required due to the degenerative disease;

(2) the client's physician has determined that no progress in the identified problem area can be expected;

(3) the county submitted the determination by the client's physician to the commissioner with the first quarterly program and fiscal review under part 9510.1130, subpart 2 and requested an exception to this item; and

(4) the county's request for an exception to this item has been reviewed by the state medical review team of the Department of Human Services and the state medical review team has verified that no progress in the identified problem area can be expected.

The commissioner shall notify the county and the provider 15 days before discontinuing payments due to termination.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1130 RECORDS, REPORTS, AUDITS, AND REPAYMENT.

Subpart 1. **Records.** The provider shall maintain complete program and fiscal records and supporting documentation identifying the services and costs provided under the special needs rate exception. The costs must be maintained in well–organized files and identified in accounts separate from other facility or program costs. Costs authorized and approved under these parts do not become part of a provider's historic cost base for the purpose of setting rates under parts 9553.0010 to 9553.0080 or Minnesota Statutes, section 252.46. The provider's records shall be kept for five years and be subject to the maintenance schedule, audit availability requirements, and other provisions of parts 9505.2160 to 9505.2245.

Subp. 2. **Reports.** The county shall submit items A and B to the commissioner.

A. A quarterly program and fiscal review of the overall effectiveness of the services to be provided under the special needs allowance unless the commissioner determines that a different schedule of reviews is needed to evaluate the success of the program or redetermine the special needs rate exception payment. The review must be submitted no more than 30 days after the end of each quarter in which a special needs rate exception is in place and must include:

(1) the provider's compliance with the application;

(2) the client's progress in attaining the measurable behavioral outcomes in the individual program plan for which the special needs rate exception was requested;

(3) the county and provider's plans to reduce reliance on the special needs rate exception; and

(4) changes implemented in the type, frequency, or intensity of the staff intervention approved under parts 9510.1080 and 9510.1090.

B. A final report submitted within 90 days of termination of a special needs rate exception which documents the following:

(1) the extent to which the program goals identified in the special needs rate exception application were accomplished;

(2) the total amount of money paid to the provider through the special needs rate exception payment for equipment and actual costs and types of equipment purchased;

(3) the amount of expenditures incurred by the provider for costs allowable under part 9510.1090, subpart 2; and

(4) the total amount of unexpended funds determined by subtracting subitem (3) from subitem (2).

Subp. 3. **Audits.** The commissioner may conduct program and fiscal audits of any provider receiving a special needs rate exception to identify any overpayments made to the provider and ensure compliance with parts 9510.1020 to 9510.1140.

Subp. 4. **Repayment.** Any overpayments to the provider included in the special needs rate exception payment must be paid back to the medical assistance program within 60 days of the date the provider receives the notice of overpayment from the county or the commissioner. No retroactive payment must be made if the provider's costs exceed the special needs rate exception payment.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1140 APPEALS.

Subpart 1. **By provider.** A provider whose application for a special needs rate exception is denied or not acted on within the deadlines in part 9510.1060, subpart 1, or whose special needs rate exception is suspended, reduced, or terminated by the county may appeal the action or decision to the commissioner. The appeal must be submitted to the commissioner in writing within 30 days of the date the provider received notification or should have received notification of the action or decision. The appeal must state the reasons the provider is appealing the county's action or decision including the bases for the county's action or decision which are disputed, the specific sections of the provider's application which the provider is relying on for the appeal, and an explanation of why the provider disagrees with the county's action or decision.

The commissioner shall review the application and supporting documentation submitted to the county and any additional documents submitted with the appeal to determine if the provider can prove by a preponderance of evidence that it is eligible for a special needs rate exception and in compliance with parts 9510.1020 to 9510.1140. Within 30 days of receipt of the provider's appeal, the commissioner shall notify the provider of the commissioner's decision. No special needs rate exception payment will be made pending the outcome of the appeal.

Subp. 2. **By county.** If the county disagrees with the commissioner's decision on the county application, the county may appeal the decision to the commissioner and request reconsideration. To be reconsidered, the appeal must be filed in writing, with the commissioner, within ten days of the date the commissioner gave notice to the county of the decision on the county application. The appeal must state the reasons why the county is appealing the commissioner's decision and present evidence explaining why the county disagrees with the commissioner's decision. Within 30 days of receipt of the county's appeal, the commissioner shall review the evidence presented in the county's appeal and send written notification to the county of the commissioner's decision on the appeal. No special needs rate exception payment shall be made pending the outcome of the appeal. The commissioner's decision on the appeal shall be final.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

MEDICAL CARE SURCHARGE

9510.2000 PURPOSE AND SCOPE.

Subpart 1. **Purpose.** The purpose of parts 9510.2000 to 9510.2050 is to govern the administration of the medical care surcharge under Minnesota Statutes, section 256.9657.

Subp. 2. **Scope.** Parts 9510.2000 to 9510.2050 apply to nursing homes, Minnesota hospitals, and HMOs operating on or after October 1, 1992.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2010 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9510.2000 to 9510.2050, the following terms have the meanings given them in this part.

Subp. 2. **Appeal.** "Appeal" means a written request made to the commissioner by a nursing home, Minnesota hospital, or HMO for a contested case hearing under Minnesota Statutes, chapter 14, regarding the amount of the medical care surcharge.

Subp. 3. **Closed or closing.** "Closed" or "closing" means the facility has suspended the practice of providing inpatient hospital services, has suspended the practice of providing outpatient services, has suspended operation as a nursing home, or is in the process of suspending services under a plan of closure approved by the department.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 5. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 6. **Federal Indian Health Service facility.** "Federal Indian Health Service facility" means a facility of the Indian Health Service, including a hospital, nursing facility, or other type of facility that provides services or a type of service otherwise covered under the state's medical assistance program, whether operated by the federal Indian Health Service or by an Indian tribe or tribal organization.

Subp. 7. **Health maintenance organization or HMO.** "Health maintenance organization" or "HMO" means a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D.

Subp. 8. **Hospital.** "Hospital" has the meaning given in part 9505.0175, subpart 16, but does not include federal Indian Health Service facilities and regional treatment centers.

Subp. 9. **Medical care surcharge.** "Medical care surcharge" means the amount of tax to be paid by a nursing home, Minnesota hospital, or HMO under Minnesota Statutes, section 256.9657.

Subp. 10. **Minnesota hospital.** "Minnesota hospital" means a hospital located in Minnesota.

Subp. 11. **Nursing home.** "Nursing home" means a facility as defined in Minnesota Statutes, section 144A.01, subdivision 5, and licensed under Minnesota Statutes, chapter 144A.

Subp. 12. **Regional treatment center.** "Regional treatment center" means a "state facility" as defined in Minnesota Statutes, section 246.50, subdivision 3.

Subp. 13. **Settle–up.** "Settle–up" means to reduce an amount subsequently owed or to make a payment after resolution of an appeal under part 9510.2040 between a nursing home, Minnesota hospital, or HMO and the department in order to settle the difference between the medical care surcharge paid and the medical care surcharge owed.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2020 MEDICAL CARE SURCHARGE.

Subpart 1. **Nursing homes.** Effective October 1, 1992, and each July 1 after, an annual medical care surcharge of $535 is levied upon each nursing home bed licensed by the Minnesota Department of Health in nonstate operated nursing homes. Each nonstate operated nursing home must pay the surcharge for those beds licensed in its nursing home as of July 1 of each year, except that if the number of licensed beds is reduced after July 1, but prior to August 1, the surcharge shall be based on the number of remaining licensed beds. A nursing home entitled to a reduction in the number of beds subject to the surcharge under this provision must demonstrate to the satisfaction of the commissioner by August 5 that the number of beds has been reduced. Payments are due in equal monthly installments on the 15th day of each month beginning November 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. The November 15, 1992, payment shall be based on the number of licensed nursing home beds in the nursing home on July 1, 1992. Beginning July 1, 1993, the surcharge will be based on the number of licensed beds in the nursing home on July 1, 1993, and will change yearly on July 1 based on the then existing number of licensed nursing home beds in that nursing home.

Subp. 2. **Minnesota hospitals.** Effective October 1, 1992, each Minnesota hospital must pay an annual medical care surcharge equal to 1.4 percent of that hospital's net patient

revenue, excluding that hospital's net Medicare revenues, as reported to the health care cost information system for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12.

For the purpose of this subpart, the definitions in items A to D apply.

A. "Fiscal year" has the meaning given in part 4650.0102, subpart 19.

B. "Health care cost information system" means the reporting system as defined by parts 4650.0102 to 4650.0174.

C. "Net Medicare revenue" means any patient revenue attributable to the Social Security Act, title XVIII.

D. "Net patient revenue" has the meaning given "revenue" in part 4650.0102, subpart 36.

Subp. 3. **Health maintenance organizations.** Health maintenance organizations must pay an annual medical care surcharge equal to six–tenths of one percent of the total premium revenues of that health maintenance organization as reported to the commissioner of the Department of Health for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th day of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12.

For the purposes of this subpart, "total premium revenues" mean:

A. premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time, normally one month; and

B. premiums from Medicare wrap–around subscribers for health benefits which supplement Medicare coverage.

If advance payments are made under item A or B to the HMO for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Subp. 4. **Installment due date, acceptable postmark.** An installment payment postmarked on or before the 12th of a month satisfies the due date requirement for the 15th day of the month.

Subp. 5. **Closed or closing nursing homes and hospitals.** The medical care surcharge as amended in 1992 does not apply to Minnesota hospitals or nursing homes closed before October 1, 1992.

Nursing homes that close or are in the process of closing after October 1, 1992, are subject to the medical care surcharge for each month after October 1, 1992, in which the home operates and maintains licensed beds.

Minnesota hospitals that close or are in the process of closing after October 1, 1992, are subject to the medical care surcharge until the first month after the hospital is completely closed.

Subp. 6. **Nursing homes and hospitals that change ownership or enter into receivership.** The medical care surcharge continues for nursing homes and Minnesota hospitals that change ownership or enter into receivership.

Subp. 7. **HMOs that cease operation.** HMOs that cease operation after October 1, 1992, are subject to the medical care surcharge until the first month after the HMO completely ceases operation. The medical care surcharge continues for HMOs that merge as long as any of the certificates of authority of the merging HMOs remain in force. If the certificate of authority for a merging HMO no longer remains in force, the medical care surcharge for that HMO will be discontinued.

Subp. 8. **Nursing homes, Minnesota hospitals, and HMOs that begin operations after October 1, 1992.** Nursing homes, Minnesota hospitals, and HMOs that begin operations after October 1, 1992, are subject to the medical care surcharge under item A, B, or C.

A. The medical care surcharge will apply to a nursing home that begins operation after October 1, 1992, effective on July 1 immediately after the home becomes licensed. The nursing home shall be billed beginning on August 15 for the period of July 1 through July 31.

B. The surcharge for Minnesota hospitals begins the month immediately after the date when data has been reported to the health care cost information system for the fiscal year two years before the year of surcharge.

C. The surcharge for health maintenance organizations begins the month immediately after the date when data have been reported to the commissioner of health for the fiscal year two years before the year of surcharge.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860; 19 SR 1419*

9510.2030 NOTIFICATION OF SURCHARGE AMOUNT.

The commissioner must give written notice to a nursing home, Minnesota hospital, or HMO of the medical care surcharge amount owed at least 30 days before the date each payment is due. Notwithstanding the requirement that the monthly installments under part 9510.2020, subparts 1, 2, and 3, are due on the 15th day of the month, if written notice from the commissioner under this part is not received at least 30 days prior to the 15th, the due date of the monthly installment will be extended to 30 days from the day the notice is actually received by the nursing home, hospital, or HMO.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2040 SURCHARGE APPEALS.

Subpart 1. **When allowed.** A nursing home, Minnesota hospital, or HMO may appeal the amount of each medical care surcharge payment assessed under Minnesota Statutes, section 256.9657.

Subp. 2. **Criteria.** To be effective, an appeal must meet the criteria in items A and B.

A. The nursing home, Minnesota hospital, or HMO must appeal to the commissioner in writing. The appeal must be received by the commissioner no later than 30 days after the nursing home, Minnesota hospital, or HMO receives notice of the medical care surcharge amount. Unless the nursing home, Minnesota hospital, or HMO can establish a different date of receipt, the commissioner shall determine the date of receipt of the notice of the medical care surcharge amount to be three days after the notice was mailed by the commissioner, excluding Sundays and holidays.

B. The appeal must specify:

(1) the basis for the dispute;

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

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

(4) a statement under oath indicating the date on which the payment notice was received by the appealing party.

Subp. 3. **Resolution.** The commissioner and the appealing party may attempt to resolve the appeal informally. If the dispute is not resolved informally between the commissioner and the party filing the appeal under subpart 2, item A, the appeal will be heard according to the contested case provisions in Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings. Upon agreement of both parties, the dispute may be resolved informally through any modified appeal procedures established by agreement between the commissioner and the chief administrative law judge.

Subp. 4. **Surcharge payment during appeal.** The monthly medical care surcharge amounts established by the commissioner before an appeal must be paid by the dates due while an appeal is pending.

Subp. 5. **Resolution of appeal.** If an appeal results in a determination that payment is due the appealing party, the commissioner shall settle–up with the appellant after the exhaustion of the appeal process. For purposes of this subpart, "exhaustion of the appeal process" means within 45 days of the date of the final decision of the court of appeals or the Minnesota Supreme Court if such a judicial review is sought. If no judicial review is sought, "exhaustion

of the appeal process" means within 45 days of the date of the final decision of the commissioner.

Subp. 6. **Monthly appeals.** An appeal must be filed for each month's disputed medical care surcharge amount due. The appeals may be consolidated in a contested case hearing under Minnesota Statutes, chapter 14. The medical care surcharge amount shall not be adjusted for any month for which an appeal was not filed.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2050 ENFORCEMENT.

According to Minnesota Statutes, section 256.9657, subdivision 7, the commissioner shall impose civil penalties and interest on medical care surcharge payments that are more than 30 days overdue.

A three percent penalty is assessed the first day past due, and each 30 days after that, up to 24 percent in the aggregate. Interest will be calculated based on the following formula: tax balance multiplied by interest rate multiplied by length of time. The rate of interest is determined according to Minnesota Statutes, section 270.75.

The medical care surcharge notice shall include the tax amount and due date, plus any penalty and interest if not paid by the due date.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*