CHAPTER 9549
DEPARTMENT OF HUMAN SERVICES
NURSING FACILITY PAYMENT RATES

9549.0010 SCOPE.

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

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

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

Published Electronically: *October 11, 2007*

9549.0020 DEFINITIONS.

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

Subp. 2. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

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

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

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

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

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

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

B. The construction contracts were let.

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

D. All zoning and building permits have been issued.

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

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

Subp. 12. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 13. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

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

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

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

Subp. 18. **Depreciation guidelines.** "Depreciation guidelines" means "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611 (Chicago: 1983). Except as provided in Minnesota Statutes, section 144A.071, subdivision 1a, paragraph (h), the useful lives in the depreciation guidelines must not be used in the determination of the total payment rate. The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155.

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

Subp. 20. [Repealed, L 2014 c 262 art 4 s 9]

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

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

Subp. 23. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 24. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 25. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 26. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 27. [Repealed, L 2014 c 262 art 4 s 9]

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

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

Subp. 30. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 31. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 32. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 33. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 34. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 35. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 36. [Repealed, L 2014 c 262 art 4 s 9]

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

Subp. 38. [Repealed, L 2014 c 262 art 4 s 9]

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

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

Subp. 41. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 42. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 43. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 44. [Repealed, L 2014 c 262 art 4 s 9]

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

Subp. 46. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 47. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

History: *9 SR 2659; L 1992 c 513 art 7 s 136; L 2014 c 262 art 4 s 9; art 5 s 6*

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9549.0030 [Repealed, L 2014 c 262 art 4 s 9]

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9549.0035 DETERMINATION OF ALLOWABLE COSTS.

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

Subp. 2. **Applicable credits.** Applicable credits must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost. Interest income, dividend income, and other investment income of the nursing facility or related organization are not applicable credits except to the extent that the interest expense on working capital debt is incurred and claimed as a reimbursable expense by the nursing facility or related organization. Interest income must

not be offset against working capital interest expense if it relates to a bond sinking fund or a restricted fund as defined in part 9549.0060, subpart 7, item B, or other restricted fund if the income is not available to the nursing facility or related organization. Gains or losses on the sales of capital assets used by the nursing facility must not be applicable credits.

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

A. In order to be adequate, documentation must:

(1) be maintained in orderly, well-organized files;

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

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

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

(5) be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in Minnesota Statutes, section 256B.441, subdivision 47, the records are necessary to resolve a pending appeal, or are required for the enforcement of Minnesota Statutes, section 256B.48.

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

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

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

Subp. 4. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 5. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 6. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 7. **Related organization costs.** Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization are includable in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing

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

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

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

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

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

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

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

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

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

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

History: *9 SR 2659; L 1992 c 513 art 7 s 136; L 2014 c 262 art 4 s 9; art 5 s 6*

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9549.0041 GENERAL REPORTING REQUIREMENTS.

Subpart 1. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 2. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 3. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 4. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 5. [Repealed, L 2014 c 262 art 4 s 9]

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

Subp. 7. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 8. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 9. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 10. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 11. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 12. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 13. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 14. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 15. [Repealed, L 2014 c 262 art 4 s 9]

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

History: *9 SR 2659; 11 SR 866; L 1992 c 513 art 7 s 136; L 2014 c 262 art 4 s 9*

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9549.0050 [Repealed, L 2014 c 262 art 4 s 9]

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9549.0051 DEFINITIONS.

Subpart 1. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 2. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 3. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 4. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 5. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 6. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 7. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 8. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 9. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 10. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 11. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 12. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 13. **Short length of stay facility.** "Short length of stay facility" means a nursing facility that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing facility by dividing actual resident days in the skilled level of care for which the nursing facility can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. 14. [Repealed, L 2014 c 262 art 4 s 9]

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136; 18 SR 2584; L 2014 c 262 art 4 s 9*

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9549.0052 ESTABLISHMENT OF GEOGRAPHIC GROUPS.

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

Subp. 2. **Group 1.** All nursing facilities in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 3. **Group 2.** All nursing facilities in counties other than the counties listed under subparts 2 and 4 must be placed in geographic group 2.

Subp. 4. **Group 3.** All nursing facilities in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, Saint Louis, Scott, and Washington counties must be placed in geographic group 3.

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

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

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9549.0053 [Repealed, L 2014 c 262 art 4 s 9]

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9549.0054 [Repealed, L 2014 c 262 art 4 s 9]

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9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care related operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the case mix and other care related operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Case Mix and Care Related Components and Indexes

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies.
Food	.1183	Producer Price Index for consumer foods.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the other operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Other Operating Costs Components and Indexes

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central states (20 percent).
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 the base year operating costs limits must be determined according to items A to E. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix operating cost standardized per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care related per diems for the base year by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other care related operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B. The total care related operating cost limit for a short length of stay facility must be 125 percent of the total care related operating cost limit. A nursing facility licensed on June 1, 1983, by the commissioner to provide residential services for persons with physical disabilities under parts 9570.2000 to 9570.3600 is exempt from the total care related operating cost limit.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and

administrative. For the purpose of computing the amount of disallowed general and administrative cost, the nursing facility's professional liability and property insurance must be excluded from the general and administrative cost category. For purposes of this item, the term property insurance means general liability coverage for personal injury incurred on the nursing facility property and coverage against loss or damage to the building, building contents, and the property of others on the premises of the nursing facility property insurance does not include any coverage for items such as automobiles, loss of earnings, and extra expenses.

E. The other operating costs limits must be determined in accordance with subitems (1) to (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

(1) For each geographic group in part 9549.0052, the commissioner shall group all hospital attached nursing facilities, short length of stay facilities, and nursing facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing facilities in each geographic group in part 9549.0052 must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing facility in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all short length of stay facilities and nursing facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled under parts 9570.2000 to 9570.3600 in each geographic group in part 9549.0052 must be 105 percent of the limit established in subitem (2).

(4) For each geographic group in part 9549.0052, the commissioner shall group all nursing facilities not included in subitem (1).

(5) The other operating cost limit for each group established in subitem (4) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing facility in the group for the base year.

Subp. 3. **Indexed limits.** For a rate year beginning on or after July 1, 1987, the total care related operating cost limits and the other operating cost limits must be determined under items A and B.

A. The total care related operating cost limits must be determined under subitems (1) and (2).

(1) The composite price index for case mix and other care related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care related operating cost limits.

B. The total other operating costs limits must be determined under subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. 4. [Repealed, L 2014 c 262 art 4 s 9]

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136; L 2005 c 56 s 2; L 2014 c 262 art 4 s 9*

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9549.0056 [Repealed, L 2014 c 262 art 4 s 9]

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

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0051 to 9549.0059, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

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

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

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle up operating cost payment rate.** The settle up total operating cost payment rate must be determined according to items A to C.

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

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

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

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

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

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

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

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

History: *11 SR 1990; L 1992 c 513 art 7 s 136; L 2014 c 262 art 5 s 6*

Published Electronically: *October 21, 2014*

9549.0058 RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with part 9549.0059.

A. A resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.

C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitem (1) or (2):

(1) the resident or applicant is assessed to require tube feeding; or

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. The publication is available through the Minitex interlibrary loan system and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.

Subp. 2. **Resident classes.** The commissioner shall establish resident classes according to items A to K. The resident classes must be established based on the definitions in subpart 1.

A. A resident must be assigned to class A if the resident is assessed as:

(1) Low ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

B. A resident must be assigned to class B if the resident is assessed as:

(1) Low ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

C. A resident must be assigned to class C if the resident is assessed as:

(1) Low ADL; and

(2) defined special nursing.

D. A resident must be assigned to class D if the resident is assessed as:

(1) Medium ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

E. A resident must be assigned to class E if the resident is assessed as:

(1) Medium ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

F. A resident must be assigned to class F if the resident is assessed as:

(1) Medium ADL; and

(2) defined special nursing.

G. A resident must be assigned to class G if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) not defined special nursing; and

(4) not defined behavioral condition.

H. A resident must be assigned to class H if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) defined behavioral condition; and

(4) not defined special nursing.

I. A resident must be assigned to class I if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) not defined neuromuscular condition.

J. A resident must be assigned to class J if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) defined neuromuscular condition or scoring three or four on behavior.

K. A resident must be assigned to class K if the resident is assessed as:

(1) High ADL; and

(2) defined special nursing.

Subp. 3. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 2 according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

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

History: *11 SR 1990*

Published Electronically: *October 11, 2007*

9549.0059 RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's class. The assessment must be conducted according to the procedures in items A to I.

A. The county preadmission screening team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.0911, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.0911, except as provided in subitems (1) and (2).

(1) The public health nurse as defined in Minnesota Statutes, section 145A.02, subdivision 18, of the county preadmission screening team or the registered nurse case manager shall assess a nursing facility applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) An applicant whose admission to the nursing facility is for the purpose of receiving respite care services need not be reassessed more than once every six months for the purpose of computing resident days under Minnesota Statutes, section 256B.441, subdivision 40, if the applicant has been classified by the Department of Health within the prior six month period. In this case, the resident class established by the Department of Health within the prior six month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.

B. Except as provided in item A, subitem 2, the nursing facility must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.0911, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.0911. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing facility that is licensed differently than the section the resident previously was placed in or a resident who has been transferred from another nursing facility.

C. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing facility.

D. Any resident who is required to be assessed by the preadmission screening team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing facility must be assessed by the nursing

facility. The nursing facility must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. Each assessment that the nursing facility is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QA&R procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

G. Within five working days following the assessment, the preadmission screening team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing facility.

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care or interagency transfer form must be submitted to the Department of Health by the nursing facility as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing facility.

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

A. A nursing facility must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall assess each resident according to QA&R procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The Physician's Statement of General Condition (item 10), Individual Dependencies (items 21 to 24 and 28), Medications (items 31 to 34), and Primary, Secondary, and Tertiary Diagnoses (on the back of the form) do not require completion. The registered nurse performing the assessment shall sign the assessment form on the day the assessment is completed.

C. Within five working days of the completion of the nursing facility's semiannual resident assessments, the nursing facility must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms and the nursing facility's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing facility must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.

D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.

Subp. 3. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments. QA&R shall not establish classifications for residents who experience an admission, transfer, hospital return, or discharge occurring during the QA&R team visit.

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

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

B. In addition to the assessment required in item A, residents who have returned to the same nursing facility after hospital admission must be reassessed by the nursing facility no less than 30 days and no more than 35 days after return from the hospital unless the nursing facility's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of care or interagency transfer form. Upon request, the nursing facility must furnish the Department of Health with additional information needed to determine a resident's classification.

D. Any change in resident class due to an assessment provided under item A must be effective on the date the resident returns to the nursing facility from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first of the month following the assessment.

Subp. 5. **Change in resident class due to audits of assessments of nursing facility residents.** Any change in resident class due to a reclassification required by part 4656.0050 must be retroactive to the effective date of the assessment audited.

Subp. 6. **False information.** If the nursing facility knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in Minnesota Statutes, section 256B.441, subdivision 43.

Subp. 7. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under part 4656.0070.

Subp. 8. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4656.0070 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0070 must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. 9. **Resident access to assessments and documentation.** The nursing facility must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing facility resident or the resident's authorized representative according to items A to D.

A. The nursing facility must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing facility. The nursing facility must include a notice that the nursing facility has chosen to appeal the rates under part 9549.0080.

B. The nursing facility must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

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

D. The nursing facility must provide each nursing facility resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within three working days of receipt of a written request from the resident or the resident's authorized representative.

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

History: *11 SR 1990; L 1987 c 309 s 24; 13 SR 130; 16 SR 93; L 1992 c 513 art 7 s 136; 18 SR 2584; L 2014 c 262 art 5 s 6*

Published Electronically: *November 6, 2014*

9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.

Subpart 1. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 2. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 3. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in subpart 10, item A,

and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

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

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

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

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

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

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

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

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

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

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

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

A. Debt shall be limited as follows:

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

(2) Working capital debt shall not be allowed.

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

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

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

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

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

A hospital attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to subpart 5, and allowable interest expense computed according to subpart 7 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in subpart 1.

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

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

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

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

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

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

(2) 16 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 8. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 9. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in unit (b) must be added to each total payment rate established in Minnesota Statutes, sections 256B.431, 256B.434, and 256B.441, to determine the nursing facility's single bedroom payment rates.

Subp. 12. [Repealed, L 2014 c 262 art 4 s 9]

Subp. 13. [Repealed, L 2014 c 262 art 4 s 9]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *9 SR 2659; 11 SR 866; 11 SR 1989; 13 SR 130; L 1992 c 513 art 7 s 136; L 2014 c 262 art 4 s 9; art 5 s 6*

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9549.0061 [Repealed, L 2014 c 262 art 4 s 9]

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9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.

Subpart 1. [Repealed, L 2014 c 262 art 4 s 9]

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

Subp. 3. **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in part 9549.0060, subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the commissioner on the basis of medical necessity.

Subp. 4. [Repealed, L 2014 c 262 art 4 s 9]

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

History: *9 SR 2659; L 1992 c 513 art 7 s 136; L 2014 c 262 art 4 s 9*

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9549.0080 APPEAL PROCEDURES.

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

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

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

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

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

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

B. The appeal must specify:

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

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

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

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

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

Subp. 3. **Resolution of appeal.** The appeal must be heard according to the contested case provisions in Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings. Upon agreement of both parties, the dispute may be resolved informally through settlement or through modified appeal procedures established by agreement between the commissioner and the chief administrative law judge.

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

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

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

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

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