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 [Repealed, L 2014 c 262 art 4 s 9]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*
Published Electronically: *October 21, 2014*

9549.0030 [Repealed, L 2014 c 262 art 4 s 9]
Published Electronically: *August 8, 2014*

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subpart 1. [Repealed, L 2016 c 99 art 1 s 43]

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. [Repealed, L 2016 c 99 art 1 s 43]

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 2016 c 99 art 1 s 43]

Subp. 8. [Repealed, L 2016 c 99 art 1 s 43]

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; L 2016 c 99 art 1 s 43*
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9549.0036 [Repealed, L 2014 c 262 art 4 s 9]
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9549.0040 [Repealed, L 2014 c 262 art 4 s 9]
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9549.0041 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 2016 c 99 art 1 s 43]

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]
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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*
Published Electronically: *August 8, 2014*

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 Subpart 1. [Repealed, L 2016 c 99 art 1 s 43]

Subp. 2. [Repealed, L 2016 c 99 art 1 s 43]

Subp. 3. [Repealed, L 2016 c 99 art 1 s 43]

Subp. 4. [Repealed, 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 [Repealed, L 2019 1Sp9 art 4 s 30]
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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. [Repealed, L 2019 1Sp9 art 4 s 30]

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; L 2019 1Sp9 art 4 s 30*

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Subp. 2. [Repealed, L 2016 c 99 art 1 s 43]

Subp. 3. [Repealed, L 2016 c 99 art 1 s 43]

Subp. 4. [Repealed, 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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