

Minnesota Attorney General: Administrative Rules Proceedings

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MINNESOTA STATE REGULATIONS

Notice of filing by the Commissioner of Administration

We have received on this date, stamped and filed 2 copies of Rules and Regulations pertaining to the Department of Public Welfare
(Agency or Board)

Regulation No. DPW 47 + 49 (amended)

Subject: Medical Assistance Program

Department of Administration
Publication, Central Services Division
Documents Section
140 Centennial Office Building
St. Paul, Minnesota 55155
Telephone: (612) 296-2874

FILED
RICHARD L. BRUBACHER
Commissioner of Administration

NOV 26 1974 2:40 pm

BY Eda Staudenmaier
AUTH. SIGNATURE EJ

Stamped and filed with the Secretary of State 11-26-74

Rev. 9-72

STATE OF MINNESOTA
OFFICE OF THE ATTORNEY GENERAL
ST. PAUL 55155

WARREN SPANNAUS
ATTORNEY GENERAL

December 3, 1974

Mr. John B. Dean
Le Fevere, Lefler, Hamilton & Pearson
1100 First National Bank Building
Minneapolis, Minnesota 55402

Re: Department of Welfare
Rule 49

Dear Mr. Dean:

On October 30, 1974 I received your letter objecting to the above-referred to rule of the State Welfare Department. After having reviewed the points raised therein, I nevertheless filed Rules 47 and 49 with the Secretary of State.

While your letter raised substantial objections to Rule 49, the scope of my review at this time was limited to the amendments recently promulgated; your objections were to the rule as it already exists, not the amendments thereto.

If you have any questions, please feel free to call me at 296-4692.

Very truly yours,

Michael B. Miller
Special Assistant
Attorney General

MBM/nm

ADOPTED AMENDMENTS TO THE

REGULATIONS

OF THE

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

RELATING TO THE

TRANSFER OF PROPERTY

UNDER THE

MEDICAL ASSISTANCE PROGRAM

DPW RULE 47

DPW Rule 47: MEDICAL ASSISTANCE

(r) Property Transfers. The establishment of initial or continuing eligibility for Medical Assistance by disposing of resources which otherwise may have been used for the applicant's or recipient's support is contrary to public policy. In some instances, such disposal of property may constitute a criminal offense on the part of the donor or the donee of the property. The following practices shall be employed in determining eligibility for Medical Assistance:

(1) Each applicant for or recipient of Medical Assistance shall be required to state whether he or she has transferred, within the preceeding three years, any real or personal property totalling in excess of $750 (or $1,000 for a couple plus $150 for each legal dependent) to any person or persons without receiving adequate consideration therefor. Any property so transferred shall be viewed as a potential resource for the maintenance needs of the applicant or recipient.

(2) The applicant or recipient who has transferred property as described in this section shall be required to provide to the county welfare agency a description (including value) of the property, the name or names of all persons who received such property and the circumstances under which the property was transferred.

(3) The applicant or recipient who has transferred property as defined in this section shall be required to make a reasonable effort in cooperation with the county welfare agency to reacquire the property transferred.

(4) The information required by 2 and the efforts made to reacquire the property required by 3 shall be entered in the case record with the appropriate eligibility determination.

(5) If the return of the property or adequate consideration for the property cannot be arranged by the county welfare agency, then the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution.

(6) A transfer of property in violation of this section shall not, of itself, constitute ineligibility for Medical Assistance.

~~(r)~~ (s) General administration. These rules and regulations shall be binding upon the county in the administration of the Program.

ADOPTED AMENDMENTS TO THE

REGULATIONS

OF THE

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

FOR DETERMINING

WELFARE PER DIEM RATES FOR NURSING HOME PROVIDERS

UNDER THE

TITLE XIX MEDICAL ASSISTANCE PROGRAM

DPW RULE 49

ADOPTED

DPW 49 Regulations for Determining Welfare Per-Diem Rates for Nursing-Home Providers Under the Title XIX Medical Assistance Program.

4900 Applicability and Purpose

4901 Authority

This regulation is enacted pursuant to the statutory authority vested in the Commissioner of Public Welfare pursuant to Minnesota Statutes, Section 256b.27 to require reports, information and audits, and pursuant to Minnesota Statutes Section 256B.04, Subdivision 2, to promulgate rules and regulations for carrying out and enforcing the provisions of Minnesota Statutes, Chapter 256B. This regulation is further promulgated pursuant to the procedures set out in Minnesota Statutes, Section 15.0412, of the Minnesota Administrative Procedures Act.

4902 Objectives

The procedures embodied herein define a system for the determination of a per-diem welfare rate for all nursing homes participating in the Medical Assistance Program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these regulations if nursing-home patients account for 50 per cent or more of the facility population.

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

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

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

SECTION 4910 - RATE DETERMINATION

4911 Method of Calculating Per Diem Rate

a. Historical rate. The method of calculating the nursing-home provider per-diem rate for skilled, ICF I, and ICF II facilities will be to determine reasonable costs for the most current fiscal year and divide by adjusted patient days according to reasonable cost provisions of 4930 and cost-reporting regulations contained in 4920.

b. Incentive factor. In no case will the historical rate so determined under 4911a. be less than ~~a comparable amount~~ the historical rate calculated for the previous year minus one-half of the difference. This provision shall not

4911 apply for rates for newly established providers under 4913a., rates set by applying exceptions provided by 4939d. and flat rates established under 4913e. For multi-level providers this provision will be applied to the facilities average historical rate.

c. Allowance for known cost changes.

1. Future cost increases or decreases that are in accordance with the reasonable cost principles of ~~4913~~ 4931, known as of the report filing date, must be added to or deducted from the historical rate determined according to 4911a. and b. Such adjustment will be restricted to the elements defined in 4911c.1(a) through (h) and shall be the annualized cost effect of such cost changes exclusive of any portion of the cost change included in the historical rate.

(a) Salary and wage changes to occur during the effective period of the welfare rate:

(1) Future changes according to labor contracts, board resolutions, written policies, or minimum wage laws.

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

(b) Changes in facilities or equipment.

(c) The annualized cost effect of complying with federal, state, or local laws and regulations and Department of Public Welfare announced policies on care or facilities.

(d) ~~Taxes--payroll-Payroll, and property and sales taxes~~ All taxes except for income taxes.

(e) Interest

(f) Depreciation

(g) Utilities and insurance

(h) Rental payments pursuant to a written lease.

(i) Raw food cost increase computed initially by multiplying $1.20 times one half the percentage increase in the wholesale price index for raw food during calendar 1973. The initial increase is $.14. For reports covering periods ending December 31, 1974 or later, this known cost increase shall be calculated as follows:

(1) Calculate the percentage increase in the wholesale price index for raw food for the period December through November.

(2) If the increase is greater than that computed for the prior year, add the difference to (1).

(3) If the increase is less than that computed for the prior year, subtract the difference from (1).

(4) Multiply one half of the resulting figure times the sum of $1.20 plus the all annual increases allowed pursuant to this section.

(j) Unidentified cost increases equal to one per cent of the facility's historical cost portion of the welfare rate or one per cent of the regional (4914b.) average historical cost portion of the welfare rate, whichever is lower.

4911 2. Cost changes determined under this provision must be based upon facts and commitments in existence as of the original filing date of the report (4921e.1.). If the provider cannot substantiate that such facts and commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to 4912c. If known cost changes calculated under (a) through (h) above do not in fact occur, the welfare rate will similarly be subject to adjustment under 4912c. If actual cost increases exceed the known cost changes determined under (a) through ~~(h)~~ (i) above, no adjustment in welfare rate will be made.

4912 Effective date, notifications and adjustments.

a. Effective date. A new per-diem rate determined by the Department will be effective the first day of the month following the provider's normal fiscal year-end except in instances in which penalty provisions of regulation 4921f. are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. ~~Notification of rate decision~~. Rate Notifications. A temporary rate notification consisting of the previous year's allowed historical cost per patient day plus 80% of the indicated allowed known cost changes per patient day will be issued and paid on receipt of the report. The Commissioner will notify the provider in writing and the respective county welfare boards of the final rate determined under these regulations ~~as well as~~ and the effective date of such rate. Included in this notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

c. Adjustments for errors or omissions. All rates determined according to DPW Rule 49 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by 4921~~j~~i. Such adjustments are limited to the three complete fiscal years preceding the date an audit commences. If the adjustment results in a payment from the provider to the county welfare board(s), the provider will have up to 120 days from the date the provider receives written notification of the adjustment. If the adjustment results in a payment ~~from the county welfare board(s)~~ to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

4913 Special Rate Setting Procedures

a. Newly constructed facilities

1. Required reports. Providers with newly constructed facilities may request an interim welfare rate. Providers who increase the facility's capacity by at least 50% may at their option be considered in this classification. The provider must submit reports as required in 4921a. for the immediate future fiscal year forecast results.
2. Report compliance. Reports will comply with all applicable sections of these regulations governing cost finding, reporting, and allowable costs to the extent feasible in the individual circumstances. Noncompliance with any provision of these regulations must be so stated together with the reasons why the provider cannot comply.
3. Interim rate establishment. The Commissioner will establish an interim rate in accordance with regulations 4911 retroactive to the first day a Medical Assistance recipient is placed in the home. Such rate shall be

4913 subject to retroactive upward or downward adjustment in accordance with all provisions of DPW Rule 49 except Section 4911b. on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with 4912a and 4921~~j~~i.

b. Rates for lesser care levels in facilities without certification classification. Providers who provide care to welfare recipients requiring less care than the care level to which the provider is certified will receive a per diem rate as follows:

1. ICF I care per diem rate in a skilled nursing-care facility will not exceed 85 per cent of the established skilled nursing-care rate for that facility.
2. ICF II care per diem rate in an ICF I facility will not exceed 60 per cent of the established ICF I rate for that facility.
3. ICF II care per diem rate in a skilled nursing-care facility will not exceed 50 per cent of the established skilled nursing-care rate for that facility.

This provision shall be applied in conjunction with 4923c.2.

c. Private room rate. A private room rate of 115 per cent of the established welfare per diem rate for the applicable care level in an individual home shall be allowed for a Medical Assistance recipient when deemed a medical or other necessity for the individual patient or as the patient's condition affects others; such condition must be determined by the attending physician and approved by the county welfare board. This provision, together with the provisions of 4939b. shall apply only to facilities applying for a Certificate of Need after August 15, 1972.

d. Care classification additions. Providers who add certified care classifications may file an amended report under 4921 that includes known cost changes associated with care classification additions to obtain a welfare per diem rate for care not previously provided. At the provider's option he may accept the lesser care rates under 4913b. in lieu of filing reports according to this provision.

e. Election of flat rate for small providers. Providers with a capacity of less than 30 licensed beds may annually elect to receive a flat per diem rate for providing required care of welfare patients by filing a flat rate report in lieu of receiving a rate complying with reporting requirements of 4921 and otherwise being subject to provisions of DPW Rule 49. The flat rate for skilled, ICF I, and ICF II for each region or group of regions as defined in 4914b. shall be ~~75 per cent of~~ the regional average rates as determined from ~~based on~~ filed reports before the maximum rate limitation and excluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins.

Such an election must be filed within reporting deadline provided by 4921e, or be subject to penalty provisions of 4921f. Such rates elected by providers will be in effect for one year.

f. Incidental welfare rate. Providers may elect to receive a flat rate under 4913e for care of welfare recipients if welfare recipients account for less than twenty per cent of the certified capacity of the home.

4914 Rate Limitations

a. Limitation based on private pay rates or relevant federal or state laws and regulations. Notwithstanding any other provisions of these regulations, the established provider rates for nursing-home care will not exceed the normal provider's rate charged private patients for comparable nursing-care services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited to federal laws or regulations that affect the Medical Assistance Program.

b. Maximum rate. Individual welfare rates will be subject to a maximum of 125 per cent of regional average costs plus known cost changes exclusive of this limitation and ~~exclusive of~~ flat rates under 4913e. Regions will be those areas designated by the Governor for regional planning and economic-development purposes. Regions may be combined when deemed appropriate by the Commissioner as announced through policy bulletins. The regional averages will be calculated separately for proprietary, ~~and~~ non-proprietary and hospital-attached facilities except the regional average costs for hospital-attached facilities shall be included in the regional average calculation for non-proprietary free-standing facilities. The maximum-rate limitations will be adjusted annually through policy bulletins. The regional averages will be determined by the Commissioner, using all available information from reports that indicate a fiscal-year end during a calendar year and will be applied to rates that become effective during the second succeeding calendar year. Facilities that have a non-calendar-year end and have been previously subject to the maximum rates may adjust the rates to the new maximum rates if previously justified by the reports.

c. Maximum rate exceptions.

1. Welfare per diem rates in excess of the maximum rate limitation will be allowed in the initial year to the extent that the welfare rate requested includes cost increases required to increase wages to the minimum standards of federal or state wage laws.
2. Provision 4914b. will not apply to homes that qualify for exception under 4939d.3. or facilities licensed under DPW Rule 80.
3. Provision 4914b. will not apply to providers with newly constructed facilities or providers who increase the facility's capacity by 50% for the first two immediate fiscal years.
4. Welfare per diem rates in excess of the maximum rate limitation will be allowed to the extent of 85 per cent of the first $2.00 per patient day over the maximum welfare rate when total allowable costs are divided by actual patient days or 93 per cent of total capacity patient days, whichever is greater.
5. Provision 4914b. will not apply to those salary cost changes which exceed 6% of the historical salaries if the salary cost changes are reasonable and are required to bring facility salaries to the salary range of comparable facilities. The salary cost changes for top management compensation are excluded from this exception.

d. Minimum rate. The minimum welfare per diem rates will be 75 per cent of the regional average as defined in 4914b.

4915 Appeal Procedures

a. Scope of appeals procedures. These procedures describe the manner by which unresolved individual provider or county welfare board disputes that may arise concerning application of these regulations excluding regulation 4915 will be settled. Unresolved disputes are defined as those disagreements which cannot be resolved informally between the provider and the Department staff normally assigned responsibility for administration, or the provider and a county welfare board.

b. Composition of appeals committee. Unresolved disputes will be heard by ~~a~~ an ~~seven-man~~ appeals committee composed of no more than nine members. ~~knowledgeable and interested people.~~ No more than three persons representing nursing homes or nursing home associations shall serve at any one time. The Commissioner shall consult with various professional organizations and select the members of the appeals committee for terms not to exceed his own term of appointment.

c. Compensation of committee members. Members of the Appeals Committee shall be compensated for time and expenses incurred in performance of required duties.

d. Frequency of committee meetings and hearings. The Appeals Committee will meet at least quarterly at a predetermined time and place to hear and determine disputes.

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

f. Appeals procedure. If the provider and the Department's staff normally assigned responsibility for the administration or the provider and a county welfare board cannot agree to a settlement of the dispute, then each party will submit in writing the facts, arguments and any other appropriate data to the Appeals Committee~~,~~ within 60 days of the department's notification of the new per diem rate. The Committee will review the dispute and may require ~~requests~~ additional information or analyses to be submitted by the Department or the provider, and then recommend to the Commissioner disposition of the dispute. Because existing state law does not permit the Commissioner to delegate his powers, final authority on disposition of disputes must be retained by the Commissioner. Unless otherwise agreed to by the parties, neither the Department nor the provider may introduce exhibits at the appeal hearing unless a copy has been provided to the other party at least 14 days prior to the hearing date or five days after receipt of an exhibit from the other party if it is in direct response to the exhibit received from the other party.

g. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the ~~amount in dispute~~ new per diem rate will prevail ~~not be adjusted~~ until final determination according to these appeal procedures is made. The total dollar amount due the provider or the county resulting from the resolved disputes will be subject to payment provision of 4912c.

h. Findings and conclusions. Any data, findings, conclusions, or opinions of the Appeals Committee and any department data in regard to any provider appeal will be made available to the provider and will become part of the Department record. The Department will prepare quarterly a summary of the decisions of the Appeals Committee rendered during the preceding quarter.

SECTION 4920 - REPORTS

4921 General Reporting Requirements and Submittal Procedures.

a. Required Reports. Except as provided by 4913e. and f., to receive a per diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the Department. Reports, supporting documentation, and worksheets will consist of the following:

1. General provider information and statistical data.
2. Financial statements consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations.
3. Reports of historical costs and known cost changes together with supporting calculations and worksheets.
4. Rate-determination worksheets.
5. Other relevant data may be required by the Commissioner to support a welfare rate request. If such data are not provided within 30 days, the Commissioner must calculate a rate, making whatever assumptions deemed appropriate to arrive at the rate in the absence of the requested data.
6. A complete statement of fees and charges.
7. The names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten per cent or more of the facility.

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

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

c. Records. The provider, where applicable, will maintain statistical and accounting records to support information in no less detail than that required by 4921a. required reports. The provider shall also make available federal and state income tax returns upon request of Department personnel.

d. Report certification.

1. Reports required in regulation 4921a. will be accompanied by a certification of (1) the majority owner defined as the person having over 50 per cent effective ownership, or the chief financial officer if there is no majority owner, and (2) the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.

4921

2. If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitte as a part of reports required by 4921a.

e. Reporting deadlines and extensions.

1. Deadlines. Required reports shall be submitted directly to the Department within three calendar months after the close of the provider's normal fiscal year.

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

f. Penalties.

1. Report preparation and submittal. The penalty for non-compliance with Regulation 4921a and 4921e. will be to reduce the reimbursement rate to 80 per cent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the Commissioner.

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

(a) Immediate adjustment of the welfare rate, along with retroactive recovery by the county welfare board of funds incorrectly paid to the provider.

(b) Termination of the provider contractual agreement.

(c) Prosecution under applicable federal and Minnesota statutes.

g. Audits. All reports will be subjected to desk audit and may be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider record keeping and accounting practices, the Commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of 4921f.1. or 2. may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by 4921a. must be prepared in accordance with reasonable cost principles in Section 4930.

~~j.~~ i. Amended reports. Except as provided in 4911c.2., providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage law changes occur unexpectedly or when long term labor contracts expire and are renegotiated subsequent to the reporting deadline in 4921 e.1. The cost change omissions to comply with minimum wage law changes or labor contracts will be limited to the wage increases required to meet the minimum standards of federal or state wage laws or reasonable labor agreements. Such changes in the welfare per diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less, for each annual period. The payment and period covered by this provision are governed by 4912c.

4922 Special Provisions for Multi-home Providers and Providers Involved in Other Business Activities.

a. Reporting exceptions. Providers who operate several homes or who are engaged in activities other than nursing care may not be able to comply with the required reports referred to in 4921a. In that case, the provider must indicate reasons for noncompliance.

b. Charges from related organizations. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the

4922 provider at the cost to the related organization. If the related organization in the normal course of business sells services, facilities or supplies to the outsiders, the cost to the provider shall be the outsider's price; however, sales to outsiders must constitute at least 25 per cent of its sales.

c. Cost allocation of top-management salaries and management fees. The allocated portion of compensation for the chairman of the board, directors, presidents, or other similarly titled individuals allocated to an individual nursing home shall be subject to the limitation provided in regulation 4933a. Other corporate charges or costs allocated to a nursing home must represent the cost of services actually rendered and be identified as to the type of service provided.

4923 Definitions

a. Care definitions. The following care classifications are used in cost reporting required by these regulations. The definitions of these terms included in DPW Rule 47 and appropriate federal regulations governing Title XIX are hereby adopted.
   1. Skilled Nursing Home (Skilled)
   2. Intermediate-Care Facility I (ICF I)
   3. Intermediate-Care Facility II (ICF II)

b. Cost categories. Costs used for rate-setting purposes and related to patient care are to be grouped according to major cost categories used in required reports. Such categories are defined as follows:
   1. Nursing - All directly identifiable costs associated with nursing care defined in Section 4923a. In general, these include bedside care; administration of medications, irrigations, and catheterizations; application of medications, dressings, or bandages; rehabilitative nursing techniques; and definition of modified diets, as well as other treatments prescribed by a physician that require professional or technical knowledge, skills, and judgment as possessed by a professional nurse. Included are comfort medications, medical supplies, devices, and other routine supplies not separately reimbursed as listed in Regulation 4923b.8. Personnel costs to be included in nursing are the salaries of the director of nursing, supervising nurses, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants (ICF II care only). The salaries or fees of physicians performing consulting services not reimbursed by separate fee schedule are also to be included in this cost category.
   2. Dietary - All directly identifiable costs of normal and special diet food including food preparation and serving. Personnel costs to be included in dietary are the salaries of dieticians, chefs, cooks, dishwashers, and all other employees assigned to the kitchen and dining room.
   3. Laundry and linen - All directly identifiable costs of linen and bedding, laundering, and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, seamstresses, laundrymen, and ironers.
   4. Housekeeping - All directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, maids, and other cleaning personnel.
   5. Plant operation and maintenance - All directly identifiable costs for maintenance and operation of the buildings and grounds, including fuel, electricity, water, supplies and parts to repair and maintain equipment and facilities, and tools. Personnel costs to be included are the salaries of engineers, painters, heating-plant employees, plumbers, electricians, carpenters, and watchmen.

6. Other care-related services - All directly identifiable costs of other services, such as recreational activities, religion, rehabilitation, arts and crafts, and social services.

7. General and administration - All directly identifiable costs for administering over-all activities of the facility, including business-office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefit costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified under definitions in 4923b.

8. Miscellaneous nonreimbursable services and expenses -
   (a) All directly identifiable costs of functions normally reimbursed by charges to patients, employees, or outsiders, such as the operating costs of a pharmacy, beauty shop, or coffee and gift shop are included here.
   (b) Also included are specific costs that may be incurred by the provider and reimbursed separately according to a fee schedule. These include but are not limited to the following:
      1. Services provided by licensed medical, therapeutic, or rehabilitative practitioners.
      2. Oxygen at prevailing prices.
      3. Wheel-chair alterations for specific Medical Assistance recipients.
   (c) Also included in this section will be costs associated with operating activities financed by gifts or grants from private or public funds.
   (d) All costs classified in 4923b.8. are not allowable for purposes of determining a per diem rate under these regulations.

c. Patient days.
   1. General definition. For purposes of determining a per diem rate, a patient day is defined as a day for which full and normal billings were rendered.
   2. Special care rates. Facilities that provide care to a patient requiring less care than the care level to which the facility is certified may adjust lesser-care patient days for rate-calculation purposes as follows:

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

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

4924 Cost Allocation Procedures

a. General provisions for all providers.
   1. Costs will be classified in accordance with categories defined in Regulation 4923b. and, if applicable, by care level defined in Regulation 4923a.

4924

2. Classification of costs to cost categories 4923b. will involve one or more of the following steps:
   (a) Direct identification, without allocation, which will be accomplished in the routine classification of transactions when costs are recorded in the books and records of the provider.
   (b) In instances in which individuals have multiple duties, the person's salary cost will be allocated to categories 4923b. on the basis of management's estimate of time spent on various activities. This procedure will not be applied to administrators or other chief executives' salaries in facilities with 60 or more licensed beds.
   (c) Other costs that cannot be classified to cost categories through use of procedure 4924a.2.(a) and 4924a.2.(b) will be classified in the administrative category.
3. Adjustments for costs otherwise reimbursed. Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in regulation 4923b.8.
4. Non-allowable cost adjustments. Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in Section 4930 of these regulations. All adjustments will be footnoted with the applicable regulation number. Costs previously excluded by 4923b.8. will not require further adjustment.

b. Specific care level allocation procedures for multi-level providers. Cost allocation procedures are necessary to determine costs among different care level facilities. Allocation procedures are defined in the following sections and will be applied in the order stated except where noted otherwise. Regardless of method selected, a reasonable identification of costs to care level must result.

1. Nursing care - Any combination of allocation procedures (a), (b), and (c) below can be used as long as the result is a reasonable approximation of actual costs incurred by care level.
   (a) Direct identification (without allocation) in the routine classification of transactions when costs are recorded in the books and records of the provider (e.g. invoice and time record account classifications).
   (b) Cost allocation on the basis of regularly validated time or cost studies.
   (c) Remaining costs (e.g. nursing supervisor, supplies, etc.) not classified under methods (a) or (b) above will be allocated on the ratio of costs identified to care levels (using (a) and/or (b) above), one care level to another.
   (d) If methods (a), (b), or (c) above cannot be used, costs will be allocated on the basis of actual patient days weighted by the ratio of maximum allowable nursing care and attendant hours as defined in regulation 4932.
2. Dietary.
   (a) Cost allocation on the basis of regularly validated time or cost studies.
   (b) Cost allocation based on the number of meals served.
   (c) Cost allocation based on the actual patient days.
3. Laundry and linen, housekeeping, and plant operation and maintenance. The following allocation procedures can be applied to individual department costs or the combination of these three departments at the option of the provider.
   (a) Same as 4924b.1.(b) - time or cost studies.
   (b) Allocation on the ratio of square feet of floor space devoted directly to each care level.

4924 (c) Same as 4924b.2.(c) - patient days.

4. Other care related services
   (a) Same as 4924b.1.(b) - time or cost study
   (b) Same as 4924b.2.(c) - patient days
5. General and administration - Cost allocation on the ratio of the combined cost by care level determined for categories 4924b.1. through 4. and 6.
6. Depreciation, interest and real estate and personal property taxes
   (a) Location of equipment when determinable.
   (b) Same as 4924b.3.(b) - square feet.
   (c) Same as 4924b.2.(c) - patient days. This allocation procedure must be used if actual patient days in any care level exceeds certified capacity patient days.
7. Earnings allowance - Cost allocation on the ratio of the combined cost by care level determined for categories 4924b.1. through 4. and 6.

c. Hospital attached facilities. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups:
   1. All expense classifications without depreciation, administration and general.
   2. Depreciation.
   3. Administration and general.

SECTION 4930 - REASONABLE COST PRINCIPLES

4931 General Provisions

a. Reasonable costs. Costs to be allowable for rate setting purposes must satisfy the following over-all criteria:
   1. They must be necessary and ordinary costs related to patient care.
   2. They must be costs that prudent and cost-conscious management would pay for a given item or service.

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

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

d. Substance over form. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in DPW Rule 49 will be disallowed under the principle that the substance of the transaction shall prevail over form.

4931 e. Costs due to changes in federal or state requirements. Costs incurred to comply with changes in federal or state laws and regulations on increased care and improved facilities are allowable costs for purposes of determining a historical per-diem rate under 4911a.

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

g. Annual review of cost limitations. The Commissioner shall review annually the dollar limitations for top management compensation limitation (4933a.) and depreciation basis limitation (4934b.) and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

h. Application of principles and specific limits. The reasonable cost principles defined in 4931 apply to all reported costs and have been specifically defined for certain cost elements in 4932 through 4939.

4932 Nursing Care and Attendant Limitations

a. Nursing care. Nursing-care costs will be limited by a maximum number of nursing hours per patient day as follows:

Skilled - 2.9 hours
ICF I - 2.3 hours

If the actual average nursing hours per patient day exceed the above limit, the reasonable cost limitation will be calculated by multiplying the ratio of the above stated limit to the average actual nursing hours per patient day for the year times the actual cost per patient day. This limitation will not apply to facilities that qualify for exception under 4939.3. or facilities licensed under DPW Rule 80.

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

4933 General and Administrative Expenses

Reasonable cost criteria for general and administrative expenses are as follows:

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

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

4933 The minimum annual compensation limitation is $10,000 or actual compensation, whichever is less, and the maximum shall be $35,000. For each full ~~four-tenths~~ percentage point increase in the consumers price index in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the months ~~January, 1974~~ October 1973, and October, 1974, new series index (1967=100), the accumulation annual compensation per paid limitation listed above shall be increased by ~~two-tenths of~~ one percent ~~rounded to the nearest dollar~~. The increase, if any, generated by this formula shall be affected in January 1, 1975. Similar calculations shall be made for each successive year using the ~~months January and~~ October indices for two successive years with the increases beginning effective the following January.

b. Assistant Administrator. Reasonable compensation of assistant administrators is not subject to the limitation in 4933a.

c. Other management services. The costs of other directors' fees, unidentified management fees, and physician compensation for performing administrative functions are allowable to the extent that such costs together with compensation of top management do not exceed the limitations defined in 4933a.

d. Other general and administrative costs.

1. Owners life insurance. The costs of premiums are not allowable.
2. Personal expenses. Personal expenses of owners or employees, such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation do not exceed the limitations of 4931c. and 4933a.
3. Professional, technical, or business-related organizations. These costs are allowable if their function and purposes can be reasonably related to the development and operation of nursing facilities, patient-care facilities, and programs for the rendering of patient-care services.
4. Social, fraternal, and other organizations. Costs incurred in connection with memberships in all organizations not included in 4933d.3. are not allowable.
5. Travel and automobile. These expenses are not an allowable expense unless they are related to activities of managing the nursing home.
6. Entertainment. These expenses are not allowable costs.
7. Advertising. Costs incurred in connection with maintaining or maximizing occupancy are allowable.
8. Pension and profit-sharing plans. Contributions to either an Internal Revenue Service approved pension or profit-sharing plan, but not both, are allowable costs.
9. Employee education costs, orientation, and on-the-job training. Costs relating to providing improved patient care or, where required by state law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories, 4923b. unless not identifiable.
10. Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.
11. Telephone, television, and radio service. These are allowable costs where furnished to the general patient population in areas of provider day rooms, recreation rooms, lounges, etc. The cost of these services when located in a patient accommodation is not allowable.
12. Noncompetitive agreement. Costs of these agreements are not allowable.

4933

13. Pre-opening costs. One time pre-opening costs of new facilities incurred prior to admittance of patients must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period no less than 120 consecutive months beginning with the month in which the first patient is admitted for care. Examples of these costs are wages paid prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.
14. Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.
15. Fund-raising costs. Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by 4936a.
16. Charitable contributions. These are not allowable costs.

4934 Depreciation

a. Basis for depreciation calculation.

1. Cost. Historical cost of nursing facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 4934a.2.
2. Change in ownership of facilities. In a case in which a change in ownership of a nursing-home facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:
   (a) In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of:
      (1) The portion of the purchase price properly allocable to depreciable nursing home facilities; or
      (2) The appraised value of the depreciable nursing home facilities calculated under the reproduction cost, depreciated method.
   (b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of 4934a.2.(a) the case of a complete change in ownership except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 per cent. Any increase allowed by this section will then be adjusted according to Section 4934a.6.
3. Redemption of ownership interests. In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying the provision of 4934a.2.(b
4. Donated assets. The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price that an able buyer would pay a willing seller in an arms-length sale or appraised value defined in 4934a.2.(a)(2), whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

4934

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

6. Recapture of depreciation resulting from sale of facility. The sale of depreciable nursing-home property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation calculated in accordance with 4934 indicates the fact that depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation.

   a. The amount of the recapture will be determined as follows:

      (1) The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after the effective date of DPW Rule 49 (November 1, 1972).

      (2) The gross recapture amount as determined in (1) above shall be allocated to fiscal periods from November 1, 1972, through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under DPW Rule 49. The amount allocated to each period shall be divided by the total actual patient days in that period, thereby determining a patient-day cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the patient-day cost for each fiscal period.

      (3) The total net recapture amount determined according to (2) above will be reduced by one per cent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the State of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of 4934a.2.

   b. The net recapture amount so determined in (3) above will be paid by the new owner to the State of Minnesota within a time period agreed to by the Commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

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

b. Limitations.

1. The total basis of depreciable nursing-facility assets shall not exceed an average of ~~$11,000~~ $13,000 per bed for licensed beds in two or more beds per room and ~~$16,500~~ $19,500 per bed for licensed private rooms built or purchased after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975 according to a construction index as determined by the Commissioner. The depreciable basis for licensed beds built or purchased prior to January 1, 1974 shall not exceed an average of $11,000 per bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private rooms which satisfy the certificate of need provision of 4913c. However, the depreciable basis for licensed private rooms built prior to August 15, 1972 shall not exceed an average of $16,500 per bed for a maximum of 5% of licensed beds.

4934

2. In no instance can accumulated depreciation calculated in accordance with 4934 exceed the basis defined in Section 4934a.
3. Accumulated depreciation as of the beginning of the first fiscal year covered by this regulation shall be calculated retroactively using the useful life concept defined in Sections 4934c. and 4934d.
4. Regardless of the applicability of the limitation stated in 4934b.1. above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by ~~state or federal~~ governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under Section 4934a. applying one of the "useful life" schedules defined in Section 4934c.1. or 4934c.2.
1. Building - 35 years
Major building improvements (depreciated over the remaining life of the principal asset or useful life, but not less than 15 years).
Land improvements - 20 years
Equipment - 10 years
Vehicle - 4 years
2. American Hospital Association depreciation guidelines.

d. Other useful lives
1. Depreciation rates for used facilities and equipment. The useful life shall be assigned by the provider considering the individual circumstances; however, the useful life will not be shorter than one-half of the useful life provided by Sections 4934c.1. or 4934c.2.
2. Leasehold improvements. The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

e. Depreciation method. The straight-line method of depreciation should be used except, at the option of the provider when the principal payments on capital indebtedness (as defined in Section 4936a.1.) exceed the total depreciation allowance calculated in accordance with Section 4934. In such instances, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and six years for equipment. Accumulated depreciation cannot exceed the basis defined in Section 4934a.

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

g. Non-depreciable assets. Nurisng-facility assets that are not depreciable include but are not restricted to:
1. Land. Includes the land owned and used in provider operations included in the cost of land and the costs of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature.
2. Goodwill. Includes amounts that result from purchase of property or stock in excess of determinable value as determined in 4934a.2.

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

4934

2. In no instance can accumulated depreciation calculated in accordance with 4934 exceed the basis defined in Section 4934a.
3. Accumulated depreciation as of the beginning of the first fiscal year covered by this regulation shall be calculated retroactively using the useful life concept defined in Sections 4934c. and 4934d.
4. Regardless of the applicability of the limitation stated in 4934b.1. above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by ~~state or federal~~ governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under Section 4934a. applying one of the "useful life" schedules defined in Section 4934c.1. or 4934c.2.
1. Building - 35 years
Major building improvements (depreciated over the remaining life of the principal asset or useful life, but not less than 15 years).
Land improvements - 20 years
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d. Other useful lives
1. Depreciation rates for used facilities and equipment. The useful life shall be assigned by the provider considering the individual circumstances; however, the useful life will not be shorter than one-half of the useful life provided by Sections 4934c.1. or 4934c.2.
2. Leasehold improvements. The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

e. Depreciation method. The straight-line method of depreciation should be used except, at the option of the provider when the principal payments on capital indebtedness (as defined in Section 4936a.1.) exceed the total depreciation allowance calculated in accordance with Section 4934. In such instances, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and six years for equipment. Accumulated depreciation cannot exceed the basis defined in Section 4934a.

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

g. Non-depreciable assets. Nurisng-facility assets that are not depreciable include but are not restricted to:
1. Land. Includes the land owned and used in provider operations included in the cost of land and the costs of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature.
2. Goodwill. Includes amounts that result from purchase of property or stock in excess of determinable value as determined in 4934a.2.

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

4935 Leased Facilities or Equipment

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

1. Rental charges result from a sale, lease-back arrangement, or lease with option to buy at a price less than anticipated value.
2. Rental charges are paid to a related or controlled organization. If either 4935a.1. or 2. exists, the provisions of 4935b. will be applied.

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

c. Rental charges incurred on leases entered into before the effective date of these regulations are includable as allowable costs except as provided in parts a. and d.

~~e.~~d. Limitation. Allowable rental charges are subject to the investment per bed limitations of 4936b.1.(a) determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of Federal Hospital.

Insurance Fund obligations as of the effective date of the lease. The formula for determination of this provision ~~will be included in the provider Manual~~ is as follows:

Present value of lease = Lease payment per period x present value factor per period

Investment per bed = Present value of lease - Licensed Beds

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

4936 Cost of Capital

a. Interest

1. Interest expense is an allowable cost and will be classified as follows:
   (a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtednes is defined as any loan that is applied to purchase fixed assets relate to providing nursing care as defined in 4936b.1.(a). The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.
   (b) Other interest for working capital and operating needs that directly relate to providing nursing care is an allowable cost. The form of indebtedness will include, but not be limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.

4936

2. Interest income will be a deduction from interest allowable under provision 4936a.1.(a) or 4936a.1.(b). Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpended donated funds carried by the institution that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

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

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

5. Allowable interest limitation for proprietary providers. Because of the provision of 4936b. for proprietary providers, the allowable interest expense defined in Section 4936a.1.(a) shall not exceed the providers average interest rate times 65 per cent of net allowable assets as defined in 4936b.1.(a).

b. Earnings Allowance for Proprietary Providers

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

(a) Net allowable fixed assets employed will include actual cost of land, land improvements, buildings and equipment, less cumulative depreciation calculated in accordance with regulation 4934 and further limited to $1,000 in excess of the limitations provided in 4934b.1.

(b) The amount of capital provided by owners will be assumed to be 35 per cent of net allowable fixed assets employed in providing nursing care.

(c) The after-tax rate of return allowed on capital provided by owners, calculated on the basis of 4936b.1.(a) and 4936b.1.(b), will be ten per cent.

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

(e) An additional earnings allowance will be allowed on the remaining 65 per cent of net allowable fixed assets not otherwise covered by capital indebtedness. The allowance will be 6 per cent of this amount.

4936 ~~c. Leased facilities. An earnings allowance to a proprietary provider who has a leased facility will be permitted to the extent that the provider can substantiate the fact that the calculated earnings of the lessee and lessor combined do not exceed the earnings allowance provided by 4936.~~

~~d.~~c. Minumum cost of capital allowance ~~for all providers.~~ Notwithstanding the provision of 4936a.5. and 4936b., the cost of capital allowance shall be no less than the combination of:

1. Actual interest on capital indebtedness, and
2. An earnings amount determined by multiplying 93 per cent of capacity patient days for a fiscal year, or part thereof if a short period report is being filed, by thirty-five cents.

~~e.~~d. Minimum cost of capital allowance for non-proprietary providers and non-proprietary leased facilities. The cost of capital allowance for non-proprietary providers and leased facilities determined in ~~4936d.2.~~ 4936c.2. shall be reduced by the per-diem effect of facility utilization incentives under 4939a.

e. Minimum cost of capital allowance for proprietary leased facilities. The minimum cost of capital allowance for proprietary leased facilities determined in 4936c. and the facility utilization incentive determined in 4939a. will not exceed the aggregate cost per patient day of seventy-five cents plus disallowed interest.

4937 Welfare

All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patient exclusively will be calculated in a manner that results in an assignment of the incremental costs stated above wholly to welfare patients. Such costs may include reasonable expenditures for utilization review, preparation and processing of a cost statement under these regulations (limited to $500 for each reporting period on actual cost whichever is less , interest payments on federal or state loans taken to purchase or remodel equipment required for federal certification if it is clearly shown that these expenditures are associated exclusively with the welfare program and benefit welfare patients exclusively.

4939 Facility Utilization Incentives

a. Capacity limitation. The allowable cost amount per patient day for depreciation, interest, property taxes, administration and earnings allowance will be calculated by dividing such allowable costs by 93 per cent of total capacity patient days for licensed beds. Facilities qualifying for the special care rates of 4923c.2. may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 per cent of total capacity patient days for licensed beds.

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

c. Licensed bed capacity. Useable or operable bed capacity may be used for purposes of the calculation required by 4939a. and b. if the provider can justify in writing, to the satisfaction of the Commissioner that licensed beds is an inappropriate measure of capacity.

d. Waiver of limitation. Providers may apply for a waiver of the provisions of 4939a. and b. in the following instances:

4939

1. For new facilities or facilities with major changes in capacity, that are applying for a certificate of need after the effective date of these regulations, the Commissioner may grant a waiver of this capacity calculation and allow a rate based on anticipated actual patient days for the period through the end of the first full fiscal year.
2. In cases of extreme hardship, nursing homes not covered by 4939d.1. and having over 65 per cent welfare patient days may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. "Extreme hardship" will include a financial situation in which projected cash flow indicates the fact that debt and operating obligations cannot be met.
3. ~~Facilities~~ Skilled care facilities which have a patient population ~~in a care level~~ with an annual average length of stay of 180 days or less.

SECTION 4950 - IMPLEMENTATION PROCEDURES

4951 Effective Date of DPW Rule 49 Revisions

a. All revisions of this revised DPW Rule 49 shall take effect beginning with reports covering fiscal years ending after July 31, ~~1973~~ 1974.

~~b. Providers may file no later than October 31, 1973, a revised or amended report to take into account the revised rule. The revised rate so determined shall be effective as of July 1, 1973.~~

b. Providers may request, by letter, no later than December 31, 1974, a revised rate as affected only by sections 4911 c.1.(i) and 4914 c.3. through 5. The revised rate may be effective as of September 1, 1974.

APPROVED AS TO FORM AND LEGALITY
11-26 1974
WARREN SPANNAUS, ATTORNEY GENERAL
BY Michael B Miller
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED — 2:30 pm
NOV 26 1974
Arlen I. Erdahl
Secretary of State

FILED
RICHARD L. BRUBACHER
Commissioner of Administration
NOV 26 1974 2:40 pm
BY Eda Staudenmaier EJ
AUTH. SIGNATURE

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS
COMMISSIONER OF
PUBLIC WELFARE

In the matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

ORDER FOR HEARING

To effectively implement Rules 47 and 49, the Minnesota Commissioner of Public Welfare deems it necessary to consider adoption of the proposed rules captioned above pursuant to the authority vested in me by M.S. 1971.

NOW, THEREFORE, IT IS ORDERED this 14th day of June, 1974, that a public hearing on the proposed rules captioned above be held in the State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Tuesday, July 16, 1974, commencing at 8:30 a.m. and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED, that notice of said hearing be given to all representatives of associations or other interested groups or persons who have registered their names with the Secretary of State for that purpose and all persons who are presently members of the Minnesota Legislature.

Dated: June 14, 1974

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

Vera J. Likins, Commissioner

National

No statement of compliance

DPW 49

(1) Limit of reimbursement to 125% of regional avg.

a. Arbitrary, capricious, & denies = protection, as metro nursing homes get greater than rural

Prior

↓

Gov. & act w/ use nursing home costs as basis - w/rel.

↓

Even more tenuous to use these as "metro" or ~~"metro"~~ "rural"

(w/a consideration at the time)

(2) This violates State & Fed Directives

- need facility-by-facility basis
- classed by levels of care.

no good exceptions →

(3) Nursing hour limits & Rooms

Feds w/ do this

Nursing hours w/ bear rel. to cost control

4932
4934

Conflict a/ auth of other agencies

Title 64 - 5% for 1 bed rooms (p.10)

ultra vires

4934 Ex post facto (p.11)

Transcript

Max rates contrary to objectives - p. 11
Rural dist. n/ valid here

4934(b) Retroactive penalty on private rooms p. 18

Rural/urban dist. n/ valid here 24-5
27 - fails to dist. diff. facilities in same area

4923 c + 4934(b) - puts welfare in reg. pos. p. 29 Planning Health

Legislative dec., n/ agency p. 105

10-30-74

TO: M. Miller

FROM: Chief Clerk Don Westhoff

The attached correspondence should be acknowledged within 10 days.

If answered by phone, please attach a memo, advising what action has been taken. Please send the original correspondence, together with copies of any reply to the Main Office for filing.

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October 28, 1974

RECEIVED
OCT 30 1974
ATTORNEY GENERAL
102 STATE CAPITOL
ST. PAUL, MINN. 55101

Mr. Warren Spannaus
Attorney General
State of Minnesota
State Capitol
St. Paul, Minnesota 55103

Re: Department of Public Welfare Rule 49

Dear Attorney General Spannaus:

On or about October 17, 1974 the Department of Public Welfare submitted for your approval proposed changes in Rule 49 of the Department's rules and regulations. That rule deals with regulations for determination of welfare per diem rates for nursing home providers under Title XIX. Our office represents the Minnesota Hospital Association which ranks among its membership a large number of non-profit nursing home providers including both hospital-attached and free-standing institutions. We are writing to urge that you disapprove of the proposed Rule 49.

Many of our objections to the proposed Rule 49 deal with matters beyond the scope of your review and, consequently, our comments here will be limited to the legality of the rule.

I. Regional Average (4914)

Without doubt, the single most aggregious provisions in Rule 49 are those which limit reimbursement to 125% of the regional average. Use of the maximum rate limitation and of the regional average as an absolute limit to recovery of costs violates the directives of both the State of Minnesota and of the United States and results in the application of a standard which is arbitrary, and capricious and a denial of equal protection.

A. The Regions Established in the Regional Development Act of 1969 bear no relationship to the rate reimbursement functions of DPW.

Under proposed Rule 49 maximum per diem rates for nursing home providers will be based on the geographic location of the nursing home.

Homes in "metropolitan" areas will be allowed a greater maximum reimbursement than those in rural areas. The regions, according to 4914 a., will be those designated by the Governor for regional planning and economic development purposes.

The regions which would be used under the proposed rule were established by executive order pursuant to Minn. Stat. 462.381, et seq., the Regional Development Act of 1969. The purpose of the Act is set out in 462.383 as follows:

> "462.383. PURPOSE. Subdivision 1. The legislature finds that problems of growth and development in urban and rural regions of the state so transcend the boundary lines of local government units that no single unit can plan for their solution without affecting other units in the region; that various multi-county planning activities conducted under various laws of the United States are presently being conducted in an uncoordinated manner; that intergovernmental cooperation on a regional basis is an effective means of pooling the resources of local government to approach common proglems; and that the assistance of the state is needed to make the most effective use of local, state, federal, and private programs in serving the citizens of such urban and rural regions.
>
> Subd. 2. It is the purpose of sections 462.381 to 462.396 to facilitate intergovernmental cooperation and to insure the orderly and harmonious coordination of state, federal and local comprehensive planning and development programs for the solution of economic, social, physical, and governmental problems of the state and its citizens by providing for the creation of regional development commissions."

Clearly the Act was set up for administrative purposes. It cannot reasonably be maintained that the legislature intended that the line drawing process of the Act would be used for such purposes as are involved in the proposed rule. The apparent purpose of Rule 49 is to establish a reasonable basis for determining the extent to

which nursing home costs should be reimbursed. The purpose of the planning act was to provide for coordination of governmental planning functions. The geographic regions established by the Governor and the state planning agency were problem oriented, that is, they wished to pool governmental functions so as to cope more efficiently with problems of a particular region. There is no indication, indeed it is very improbable, that, in establishing these regions, the Governor used area nursing home costs as a criterion.

The legislature further indicated that there was nothing sacred about the boundary lines by giving counties an opportunity to request in which district they wished to be.

The only indication in the planning act that nursing homes are even remotely connected with the Act is found in section 462.39 which reads in pertinent part:

> "The comprehensive development plan shall recognize and emcompass physical, social, or economic needs of the region, and those future developments which will have an impact on the entire regions including but not limited to such matters as land use, parks and open space land needs, the necessity for and location of airports, highways, transit facilities, public hospitals, libraries, schools, public and private, housing and other public buildings." [underlining added]

Although the necessity for and location of hospitals may have been a consideration in the regional line drawing process, this is, at best, a tenuous connection with nursing home costs.

As tenuous as the use of these regions may be for rate limitation purposes it is even more tenuous to use these regions, as the department has done, to determine the metropolitan or rural character of the area. This characterization played no part in the boundaries drawn by the Governor and cannot be realistically deemed to have been one of his considerations. The regional average is therefore not a regional average at all, but an average based upon two classifications: rural and metropolitan. The "metropolitan counties" are Ramsey, Anoka, Washington, Hennepin, Carver, Scott, Dakota, Carleton, Aitkin, Itasca, Koochiching, St. Louis, Lake and Cook. All other counties are "rural."

Because the classification of rural or metropolitan is used to determine medical assistance reimbursements, the classification must not be such as would deny those affected the equal protection of the laws. In Truax v. Corrigan, 257 U.S. 312 (1921) the United States Supreme Court stated that when there is a classification:

> " . . . it must regard real resemblances and real differences between things, and persons and class them in accordance with their pertainence to the purpose at hand."

In Hernandez v. Texas, 347 U.S. 475 (1954) the court went on to note:

> "When the existence of a distinct class is demonstrated, and it is further shown that the laws, as written, single out that class for different treatment not based upon some reasonable classification, the guarantees of the Constitution have been violated."

In order for the rural-metropolitan classification to be valid, then it must rest upon real distinctions and real similarities, and it must not exclude from one classification those who share the characteristics of that class. The metropolitan-rural classification adopted by DPW based upon the planning regions entirely fails to meet constitutional muster. One example should suffice. Among the most important characteristics of a metropolitan area is high population density. Region 3, a metropolitan region for DPW purposes, has a population, according to the 1970 census, of 325,279. Region 10, on the other hand, is classified by DPW as rural but has a population, according to the 1970 census of 376,133. Further, Region 3 is approximately three times the size of Region 10. The net result is that "rural" Region 10 has substantially more than three times the population density of "metropolitan" Region 3.

While it may be true that valid cost differences may exist between nursing homes located in rural areas and nursing homes located in metropolitan areas, and that a valid classification system may be predicated upon those distinctions, the rural, metropolitan classification system erected by DPW fails to separate metropolitan from rural and therefore amounts to denial of equal protection.

B. The Regional Average - Maximum Rate Limitation Provision Violates Directives from Both the State and Federal Governments.

Under the Social Security Act and Regulations promulgated pursuant thereto a state plan may provide for reimbursement either on a facility-by-facility basis or on the basis of reasonable classification of facilities based on levels of care. The applicable regulations provide:

S.N.F.:

"45 CFR Section 250.30 (b)(3)(ii) Skilled Nursing Home Services, . . .
. . . Schedules will be acceptable if within the upper limits either on a facility-by-facility basis or on the basis of average payments according to a reasonable classification of facilities based on levels of care."

I.C.F.:

"45 CFR Section 250.30 (b)(3)(iiiZ) published in Federal Register Volume 39, No. 12 Thursday, January 17, 1974, Page 2235 uses language identical to that of the S.N.F. provision."

"(iii) Intermediate care facility services. Customary charges which are reasonable [SIC]. Schedules of payments established by the state agency will not exceed an upper limit based on the average per diem rate paid for skilled nursing facility services in the state. Schedules will be acceptable if within the upper limits either on a facility-by-facility basis or on the basis of average payment according to a reasonable classification of facilities based on levels of care. (A financial audit of the facilities is not required, but the state will establish schedules of payment which are consistent with the intent that the upper limits do not exceed average amounts paid for skilled nursing facility services."

Proposed Rule 49 does not provide for payment on a facility-by-facility basis. The alternative allowed by the above regulations is "a reasonable classification of facilities based on levels of care." Rule 49, however, bases its maximum rates on geographic regions in addition to levels of care. This method has the potential of contravening the obvious intent of the federal regulations: To provide for a fair distribution of available funds based on either the individual provider costs or the level of care provided. This potential is even more likely to manifest itself in inequitable allocations when the system used is based on regional areas which were established for purposes unrelated to nursing home costs. Rule 49 may thus be in violation of the provisions of applicable federal regulations.

Furthermore, Minnesota Statutes, Section 256B.04, Subd. 2 provides that the state agency shall:

> "Make uniform rules and regulations, . . . to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program . . ."

The following situation aptly shows that Rule 49 1) Will not provide for uniform administration of the program, 2) Has no regard for the conditions for each case and 3) Does not carry out the spirit and purpose of the program. Under Rule 49 the Elk River Nursing Home, which falls in a "rural" region will be eligible for payments of up to $17.20. Comparable nursing homes in Anoka County, on the other hand, may receive payments of $22.90, a difference of $5.70 per person per day. This disparity exists despite the proximity of the two communities (approximately 10 miles) and the fact that both communities are served by essentially the same labor pool and subject to virtually the same costs. The evidence presented to the department unquestionably establishes that similar situations exist throughout the state.

In summary, the regional average provision contained in Rule 49 does not comply with the federal guidelines for state plans of reimbursement for ICF and SNF nursing homes nor is it consonant with Minnesota statutory provisions. Assuming arguendo that payments may be made in a regional basis, the system provided for in

Rule 49 is neither a rational nor equitable application of the regional concept because 1) it uses regions which were established for purposes unrelated to nursing home costs and 2) it fails to provide for meaningful exceptions to be applied when nursing homes, for good cause, exceed the arbitrary limits contained in the regional averages.

II. Appeal Procedure

The provision for appeal of a dispute concerning the application of Rule 49 is a misnomer. The term "appeal" has come to have a fixed meaning in the law.

> "The removal of a cause from a court of inferior to one of superior jurisdiction, for the purpose of obtaining a review and retrial." Hall v. Kincaid, 64 Inc. App. 103, 115 N.E. 361.

The provision contained in Rule 4915 and called an appeal is nothing of the sort. Rather, it is a review of the matter by a board which has only the authority to recommend action to the department. The department is then free to accept or reject the recommendation as it sees fit. The department has therefore created for itself the dual role of advocate and judge in the same proceeding. Portrayal of those inconsistent roles has long been considered a denial of due process in other contexts.

III. Nursing Hour and Private Room Limitations

The nursing hour limitations contained in Rule 4932 and the private room limitations contained in 4934 represent unwarranted intrusions by the department into the activities of nursing homes.

A. In Its Various Health Care Reimbursement Programs the Federal Government Has Carefully Avoided this Interference.

Time after time the Congress of the United States has legislated that the Federal Government should keep hands off the provision of health care. The Hill-Burton Act, 42 U.S.C. 291m. provides:

> "Except as otherwise specifically provided, nothing in this subchapter shall be construed as conferring on any Federal officer or employee the right to exercise supervision or control over the administration, personnel, maintenance in operation of any

facility with respect to which funds have been or may be expanded under this subchapter."

The Hill-Burton prohibition against Federal Control has been reaffirmed on numerous occasions. For example, the Medicare Statute of 1965 bars federal employees from exercising supervision or control over the practice of medicine and the provision of medical services.

"Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person." 42 U.S.C. 1395.

In the 1972 amendment to the Social Security Act Congress again determined that the medical profession - and not government - should decide what health care standards should be required. Senator Wallace Burnnett, the author of the amendment explained it as follows:

"An effective comprehensive professional review mechanism can materially ease problems of utilization and quality control. This is the area where a bridge is needed between medicine and government. It was all too clear to those of us on the Finance Committee that an army of Government and insurance company employees checking on each medical service was not the answer. The PSRO amendment represents the best, and perhaps the last, opportunity to fully safeguard the public concern with respect to the cost and quality of medical care while, at the same time, leaving the actual control of medical practice in the hands of those best qualified - America's physicians." 118 Cong. Rec S. 16122 (early ed. September 27, 1972).

Therefore, the provisions in Rule 49 dealing with private rooms and nursing homes exceed the historical limitation which Congress has attached in controlling expenditures of federal funds.

B. The Private Room and Nursing Hour Limitations Bear No Direct Relationship to Cost Control.

The nursing hour and private room limitation are not based upon the reasonable costs for such services, but rather are limitations upon the amount and type of service which the nursing home may provide. As a result, the department's commitment to reasonable cost reimbursement is ignored.

A hypothetical example will demonstrate this phenomenon:

1. SNF "X" pays its nurses $6.00 per hour which is $1.00 more per hour than any comparable facility in the same market area. Its nursing hours per patient day are 2.9 hours. As a result, the facility has an allowable cost of $17.40 per patient day for nursing services.

2. SNF "Y" pays its nurses $4.50 per hour which is lower than is paid to nurses by comparable facilities in the same market area, and is $1.50 less than the amount paid by SNF "X". SNF "Y"'s nursing hours per patient day are 3.86 which is nearly one hour above the limit established in 4932. SNF "Y"'s actual cost for the full 3.86 hours of care is $17.37. SNF "Y" therefore has provided nearly one hour more nursing care per patient per day than SNF "X" at about the same cost.

When 4932 is applied to this situation, although SNF "Y" has provided more care for less money, it is entitled to include as an allowable cost only $13.05 per patient day. This is fully $4.35 cents less than SNF "X" can claim and $4.32 less than actual costs.

The net effect of this example is that 4932 rewards the home which furnishes less care at higher cost and penalizes the home that provides more care at a less unit cost. Such a result is clearly a subversion of the whole philosophy underlying the medical assistance program.

C. The Nursing Hour and Private Rate Limitations Conflict with the Authority of Other Agencies.

Minnesota Statutes, Section 144.56 invests the State Department of Health with the authority to establish standards for nursing home care. Pursuant to that grant of authority the Department of Health promulgated its Rule 50 dealing, inter alia, with nursing services. Rule 50 reads in relevant part:

> "(1) The nursing home shall have on duty at all times a sufficient number of qualified nursing personnel which includes registered nurses, licensed practical nurses, nurses aids and orderlies to meet the needs of the patients on all nurses' stations, on all floors and in all buildings if more than one building is involved. This includes relief duty, weekends and vacation replacements. On and after July 1, 1973, a minimum of two (2) hours of nursing personnel per 24 hours plus additional qualified nursing staff commensurate with the needs of the patients shall be provided."

Failure to fully comply with this requirement is a basis for suspension, revocation or non-renewal of the home's license. Minn. Stat., 144.55 (1). Thus a nursing home which is faithfully following the mandate of DPW on "efficiency and economy" may find its license revoked by the MHD.

Pursuant to its statutory authority the Department has also promulgated Rule 64 dealing inter alia with single rooms. That provision provides that at least 5% of the rooms in newly constructed facilities shall be private (one bed).

Even more important are the provisions of section 145.71 et seq., the Certificate of Need Law. These provisions require that no new facility may be constructed, or existing facility expanded or modified unless it has obtained a Certificate of Need. Certificates of Need presumably can require with specificity the mix of private and non-private rooms.

The fact that other agencies are now regulating, with specific authority, in the areas claimed by DPW is a further indication that DPW is exceeding the scope of its authority. It cannot be doubted that the responsibility to determine adequate nursing care levels, and proper private to non-private bed mix has without the Department of Public Welfare. Their insinuation into this area serves only to confuse the requirements for nursing care providers and detracts from the primary obligations of other agencies.

D. The 5% Private Room Limitation Unfairly Discriminates Against Existing Facilities.

While proposed facilities may be able to adjust their construction plans to meet the requirements of 4934, existing facilities which were constructed with a mix greater than is allowed by DPW, are trapped even though their mix was perfectly proper when the facility was constructed. The injustice of basing a regulation upon factors over which the provider has no control undoubtedly led the other agencies to apply their physicial-plant-predicated requirements prospectively only.

It may be argued that the provider can shut down its excess private rooms in order to avoid the cost-reimbursement squeeze, but such action will not eliminate the fixed costs generated by the mere presence of the rooms; nor is the reduction of nursing home services in the best interests of the people of the State.

IV. Conclusion

While controlling and containing the costs of medical care may be viewed as a legitimate function of the Department of Public Welfare, it is nevertheless limited in its quest to acting within the law and within the scope of its authority. It is the firm position of the Minnesota Hospital Association that the Department has ignored its mandate with respect to the regional average provisions, the appeal provision and the nursing hour and room mix provisions. Not only do these provisions violate constitutional standards and constitute an abuse of federal and state requirements, but in the case of nursing hours and room mix they directly conflict with clear legislative delegations to other departments and agencies.

We therefore respectfully request that the office of the Attorney General disapprove Rule 49.

Yours very truly,

LeFEVERE, LEFLER, HAMILTON
and PEARSON

By John B. Dean
John B. Dean
Attorneys for Minnesota Hospital Association
1100 First National Bank Building
Minneapolis, Minnesota 55402

JBD:nj

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

BEFORE VERA J. LIKINS
COMMISSIONER OF PUBLIC WELFARE

NOTICE OF HEARING

Notice is hereby given that a public hearing will be hald pursuant to Minn. Stat., Section 15.0412, Subd. 4 (1971), in the above-entitled matters in the State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Tuesday, July 16, 1974, commencing at 8:30 a.m. and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard concerning the adoption of the proposed rules captioned above by submitting either oral or written data, statements or arguments. Statements or briefs may be submitted without appearing at the hearing.

In order to facilitate a more orderly and efficient hearing, it is hereby requested that persons who will attend the hearing notify the Commissioner and submit prepared statements or briefs by Monday, July 15,1974. This request is not a requirement, nor will it limit any person's opportunity to be heard or submit statements during or after the hearing. Oral comments on the proposed rules will be taken in the order that the rules are listed above.

Copies of the proposed rules are available upon request to Department of Public Welfare, Centennial Office Building, St. Paul, Minnesota 55155.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Dated: June 14, 1974

Vera J. Likins, Commissioner

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

JEAN E. ROBERSON, being duly sworn on oath deposes and says:

1. That she is an employee of the Department of Public Welfare of the State of Minnesota.

2. That on the 10th day of June, 1974, she went to the Secretary of State's Office for the State of Minnesota and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules pursuant to Minn. Stat. § 15.0412 (1971).

3. That on the 10th day of June, 1974, in response to the above request, the Secretary of State provided her with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Jean E. Roberson
JEAN E. ROBERSON

Subscribed and sworn to before me
this 6th day of November, 1974.

Lorraine C. Pfeiffer
Lorraine C. Pfeiffer
Notary Public, Dakota County, Minn.
My Commission Expires Sept. 29, 1979.

LORRAINE C. PFEIFFER
Notary Public, Dakota Co. Minn.
My Commission Expires Sept. 29, 1979

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103-105 1st St. S.E., Little Falls

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[redacted]

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Kurtz, Mrs. Kirsten, Minn. Nurses Assn., 1821 Univ Ave., St. Paul 55104

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Minneapolis & Hennepin County Mental Health Clinic, 619 S. 5th St.,Mpls

Minnesota Legislative Comm. of Blind, 1605 Eustis, St. Paul 8

Minn. State Pharmaceutical Ass'n., 2388 Univ. Ave., St. Paul 4
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Neff, Dr. Walter S., Virginia

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Southwestern Mental Health Center, 306 N. McKenzie St., Luverne

Upper Mississippi Mental Health Center, Attn: Dr. Howard C. Reid, 510 Beltrami Ave.

Veterans' Affairs, Veterans Service Bldg., St. Paul

[redacted]

Welfare Rights Organization, c/o Stephen Parsons, 1118 Newton Ave. N. Minneapolis55

West Central Mental Health Center, 323 W. 6th St., Willmar

NURSING HOMES ONLY

STATE OF MINNESOTA
OFFICE of SECRETARY of STATE

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MPLS MN
55416

STANSFIELD ARLENE LAND OLKS
PO BOX 116
MPLS MN
55440

STD AM LIFE & ANNUITY CO
3801 W 50TH ST
MPLS MN
55410

STEELWORKERS CREDIT UNION
BOX 250
BABBITT MN
55706

STUPKA & MOREM
MIDTOWN BLDG
AUSTIN MN
55912

SULLIVAN J KIRK
PO BOX 200
BOISE ID
83701

MINN-WISC BOUNDARY AREA COMM
600 2ND ST
HUDSON WI
54016

MOFFITT R.C. DIR.ENV.CONTROL
MPLS.CITY HALL RM 301M
MPLS MN
55415

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

NATL COUNCIL JEWISH WOMEN
4330 CEDAR LK RD
MPLS MN
55416

NATL FAMILY INS CO
2147 UNIV AVE
ST PAUL MN
55114

NELSON DONALD E NSP CO
414 NICOLLET AVE
MPLS MN
55401

NEDELL HAROLD - MEINEKE
6300 W LOOP S SUITE 200
HOUSTON TX
77027

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
55415

NYQUIST DEAN A
3707 53RD PL N
BROOKLYN CTR MN
55429

O'BRIEN J.DENNIS
1200 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

OLD COLONY GAS & OIL COMPANY
17TH AVE N AT 2ND ST
MPLS MN
55411

OSTRUM DONALD E
10213 PIERCE ST NE
BLAINE MN
55434

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PAYNE COL ALVIN

DEGRAFF MN
56233

PETERSEN JOHN W
525 OSBORN BLDG
ST PAUL MN
55102

PHAR MFGRS ASSN WM D PATTON
1155 15TH ST NW
WASHINGTON DC DC
20005

PORTER LYLE O

TRACY MN
56175

PORT AUTH CITY OF ST PAUL
330 MINNESOTA BLDG
ST PAUL MN
55101

PULSCHER RBT SPRINGSTED INC
813 OSBORN BLDG
ST PAUL MN
55102

RACHNER MARY JANE
1917 PINEHURST AVE
ST PAUL MN
55116

RANALLO CLARENCE
800 CENTRAL AVE N E
MPLS MN
55413

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MN. ASN.C&IND H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MINN AFL-CIO, L O LA SHOMB
414 AUDITORIUM ST
ST PAUL MN
55102

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN AUTOMOBILE DEALERS ASSN
GRIGGS MIDWAY BLDG
ST PAUL MN
55104

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN DENTAL HYGIENISTS
5041 YVONNE TERRACE
MPLS MN
55436

MINN ENV LAW INST INC
PO BOX 15076 COMM STA
MPLS MN
55415

MINN FARMERS UNION PRES OFF
1275 UNIV AVE
ST PAUL MN
55104

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN HWYS MANAGEMENT SERVICE
410 HWY BLDG
ST PAUL MN
55101

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MINN PUB INT RES DAYTON
2418 UNIV AVE SE
MPLS MN
55414

MINN RETAIL FEDERATION
7600 PARKLAWN STE 457
MPLS MN
55435

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MINN STATE OPTOMETRIC ASSN
333 E HENNEPIN AVE
MPLS MN
55414

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2383 UNIV AVE
ST PAUL MN
55114

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MN. ASN.C&IND H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MINN AFL-CIO, L O LA SHOMB
414 AUDITORIUM ST
ST PAUL MN
55102

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN AUTOMOBILE DEALERS ASSN
GRIGGS MIDWAY BLDG
ST PAUL MN
55104

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN DENTAL HYGIENISTS
5041 YVONNE TERRACE
MPLS MN
55436

MINN ENV LAW INST INC
PO BOX 15076 COMM STA
MPLS MN
55415

MINN FARMERS UNION PRES OFF
1275 UNIV AVE
ST PAUL MN
55104

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN HWYS MANAGEMENT SERVICE
410 HWY BLDG
ST PAUL MN
55101

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MINN PUB INT RES DAYTON
2418 UNIV AVE SE
MPLS MN
55414

MINN RETAIL FEDERATION
7600 PARKLAWN STE 457
MPLS MN
55435

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MINN STATE OPTOMETRIC ASSN
333 E HENNEPIN AVE
MPLS MN
55414

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2383 UNIV AVE
ST PAUL MN
55114

FORBES GORDON MINN RRS ASSN
203 HANOVER 480 CEDAR
ST PAUL MN
55101

FOX W.E. LINDQUIST & VENNUM
4200 IDSCTR 80 S.8TH ST
MINNEAPOLIS MN
55402

F W WOOLWORTH CO
3316 W 66TH ST
EDINA MN
55424

GEORGE K GRANSE CO
1477 SELBY AVE
ST PAUL MN
55104

GIEL DAVID
RM B-28 STATE CAPITOL
ST PAUL MN
55155

GRAHAM THOS H
854 MIDLAND BK BLDG
MPLS MN
55401

GRANATH MARVIN -HONEYWELL
2701 4TH AVE SO
MPLS MN
55408

GUSTAFSON MRS D MINN VET MED
24 S 6TH ST
MPLS MN
55402

GUSTAFSON WALLACE
BOX 567
WILLMAR MN
56201

HARVEY MICHAEL
1390 W M HAHA PKWY
MPLS MN
55409

HALLBERG LEE & MCCABE
4927 34TH AVE S
MPLS MN
55417

HARTFELDT WILL
415 HAMM BLDG 6TH ST
ST PAUL MN
55102

HEAD & TRUHN
1007 SOO LINE BLDG
MPLS MN
55402

HILL JIM ASSOC.MILK PROD.
7850 METRO PARKWAY
MINNEAPOLIS MN
55420

HOPKINS WM.B. DIR.MISCCA
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY MN
55422

HOUSE ED STANDING SUB COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HULSTRAND AND)N & LARSON
PO BOX 130
WILLMAR MN
56201

HUNT MRS CHAS L MECCA
26 E EXCH CENTRAL MANOR
ST PAUL MN
55101

HUNT JAMES P JR
11470 GALTIER DR
BURNSVILLE MN
55378

INGEBRIGTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

INGVALSON VERN MN.FARM BUR.
3110 WOODDALE DR PO 337
OST PAUL MN
55165

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IVERSON GARY L
1212 PIONEER BLDG
ST PAUL MN
55101

JACKMAN DONALD G
4023 E LAKE ST
MPLS MN
55406

JENOS INC
525 LAKE AVE SO
DULUTH MN
55801

JOHNSON M.D. FRUNDT & FRUNDT

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

KANE ANTHONY
176 E FIFTH ST
ST PAUL MN
55101

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNOWLES, LARRY D
8025 33RD AVE N
CRYSTAL MN
55427

KOLLER MR & MRS ERWIN A
1568 DULUTH ST
ST PAUL MN
55108

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANSING & OAKES
400 SIBLEY ST
ST PAUL MN
55101

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LAUNDERERS&DRY CLEANERS ASSN
W 1ST NATL BK BLDG
ST PAUL MN
55101

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENATE
CENTENNIAL STUDENT UN
MANKATO MN
56001

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MECCA R.F. NELSON
26 E EXCHANGE ST
ST PAUL MN
55101

MET OPEN SPACE INFOR PROJ
111 E FRANKLIN AVE SO
MPLS MN
55404

MET TFR MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

ARROWHEAD REGIONAL DEV COMM
900 ALWORTH BLDG
DULUTH MN
55802

ARVER JOHN A
2467 COHANCY
ST PAUL MN
55113

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
ST PAUL MN
55103

AUTOMOBILE MFRS ASSN INC
55 SHERBURNE AVE
ST PAUL MN
55103

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BECKLIN ROBERT C
447 N W 4TH
CAMBRIDGE MN
55008

BEECHER EVERETT
10 10 1ST ST SO
HOPKINS MN

BENSONI PETER USW OF AM.
609 PROVIDENCE BLDG.
DULUTH MN

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BREHL JAMES W
332 HAMM BLDG
ST PAUL MN
55102

BROEKER JOHN
2850METRO DR. SUITE 504
BLOOMINGTON MN
55420

BROOKS WILLIAM F JR
854 MIDLAND BK BLDG
MPLS MN
55401

BRUNING C.R.DEPT.CLINIC.EXP.
BURTON HALL
MPLS. MN
55455

BURGER ALBERT
600 DEGREE OF HONOR BLD
ST PAUL MN
55101

CAIN RUTH
730 E 38TH ST
MPLS MN
55407

CARPENTER MRS MARY LEE
DOW CHEMICAL 47 BLDG
MIDLAND MICH.
48640

CARRISON DALE K
MANKATO STATE COLLEGE
MANKATO MN
56001

CHAMBERLAIN JOHN L
PO BOX 241
MPLS MN
55440

CHAMBERLAIN WARREN D
887 SW 4TH AVE
FARIBAULT MN
55021

CITY CLERK
386 CITY HALL
ST PAUL MN
55102

CITIZENS LEAGUE
530 SYNDICATE BLDG
MPLS MN
55402

COLLIN LAURENCE
RT 2
ISANTI MN
55040

COMMUNITY DESIGN CENTER
118 E 26TH ST
MPLS MN
55404

COUNTY ATTYS COUNCIL
95 SHERBURNE AVE S203
ST PAUL MN
55103

COX AND KING
600 BUILDERS EXCH
MPLS MN
55402

DAILEY THOS M
E-1500 1ST NATL BK BLDG
ST PAUL MN
55101

DANIELSON RODNEY L
418 AUDITORIUM
ST PAUL MN
55102

DAVIS HENRY
6301 SHINGLE CREEK
BROOKLYN CTR MN
55429

DISPATCH PIONEER PRESS
PRESS RM STATE CAPITOL
ST PAUL MN
55101

DORSEY MARQUART
2400 1ST NATL BANK BLDG
MPLS MN
55402

DUDLEY E H
RT 7 BOX 122
EXCELSIOR MN
55331

DUNN OLIVER PLUMBERS LOC
708 SO 10TH ST
MPLS MN
55404

EDINA FIRE D JAMES MCNELLIS
4801 W 50TH ST
EDINA MN
55424

ELDER DR JAMES B
11140 WASHBURN AVE SO
BLOOMINGTON MN
55431

EMERICK RICHARD A
1908 IDS CENTER
MPLS MN
55402

EMP HANDICAPPED PERSONS C
527 JACKSON RM 227
ST PAUL MN
55101

ERNEST K LEHMANN & ASSOC.
1409 WILLOW ST.
MPLS MN
55403

ESSE KENNETH
4801 W 50TH ST
EDINA MN
55424

EWALD DOUGLAS MINN HOSP ASSN
2333 UNIV AVE SE
MPLS MN
55414

EWING MRS WM
42 ASTAR RD
BABBITT MN
55706

FELHABER R S
W 1ST NATL BANK BLDG
ST PAUL MN
55101

FINLEY JAMES F
920 MINN BLDG
ST PAUL MN
55101

FLETCHER RONALD
7900 XERXES AVE S
MPLS MN
55431

FITZGERALD DR BOB
3007 LYNDALE AVE SO
MPLS MN
55408

FRANKLIN ROBERT B MPLS TRIB
426 PORTLAND
MPLS MN
55415

GALVIN M J JR
W2162 1ST NATL BK BLDG
ST PAUL MN
55101

GLEN. HILLS HOSP.R.VAN HAUER
3901 GOLDEN VALLEY RD.
MPLS. MN
55422

GREEN DEL CITY MGR
BLOOMINGTON CITY HALL
BLOOMINGTON MN
55431

HAYES,THOMAS W
700 SELLWOOD BLG
DULUTH MN
55812

HEINTZ MARY ELLEN
PO BOX 599
CINCINNATI OH
45201

HOJLE MELVIN
881 W HWY 96
SHOREVIEW MN
55112

HULTMAN WARREN R
C/O BARBAROSSA R3
OSSEO MN
55369

HUTCHISON R.M. ANOKA CO.COMP
COURT HOUSE
ANOKA MN
55303

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

IZAAK WALTON LEAGUE MN DIV
105 TIMES BLDG 57 S 4TH
MPLS MN
55401

FURLONG DR JOHN
RT 1
BOVEY MN
55709

GAS HUT INC
4940 VIKING DR
MINNEAPOLIS MN
55435

GODIN RALPH J
3824 47TH AVE SO
MPLS MN
55406

GREEN GARY J
41 SHERBURNE AVE
ST PAUL MN
55102

H B FULLER CO
2400 KASOTA AVE
ST PAUL MN
55108

HESS DONALD MIDWEST PLANN
2101 HENN BLDG
MPLS MN
55405

HICHINGER-MARK PLANNING
421 WABASHA ST
ST PAUL MN
55102

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HUMAN RIGHTS DEPT
60 STATE OFF BLDG
ST PAUL MN
55101

IUOE LOC 49 CHAS SWENSON
2580 UNIV AVE
ST PAUL MN
55101

JENSEN CARL A
127 E MAIN ST
SLEEPY EYE MN
56085

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

KABLE RICHARD W

BETHEL MN
55006

KIMBALL ROBERT
647 CAPITOL SQ BLDG
ST PAUL MN
55101

KING,TIMOTHY
3333 OAKLAND AVE S
MPLS MN
55407

KNUTSON DR KEITH,BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KORTZ MRS LOUISE
1064 FOREST HILLS DR SW
ROCHESTER MN
55901

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LAUNDERERS&DRY CLEANERS ASSN
W 1ST NATL BK BLDG
ST PAUL MN
55101

LEAGUE MN MUNIC MC HADICK
3300 UNIV AVE S E
MPLS MN
55414

LOOS CALVIN J
6809 LYNDALE AVE SO
MPLS MN
55423

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MANTHEY T J PICKANDS MATHER
1100 SUPERIOR AVE
CLEVELAND OH
44114

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MERRITT GRANT POLLUTION C
OAK & DELAWARE
MPLS MN
55440

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

CLARKSON J.B.
2350 I.D.S. CENTER
MINNEAPOLIS MN
55402

COLEMAN NICHOLAS D
700 LINWOOD AVE
ST PAUL MN
55105

CONCORDIA COLLEGE
DEAN
MOORHEAD MN
56560

CONSUMER SERVICES DEPT COMM
230 STATE OFF BLDG
ST PAUL MN
55101

CROW WING CO PLANNING & ADV
COURT HOUSE
BRAINERD MN
56401

CUSHMAN J S DAYTON HUDSON
700 NICOLLET MALL
MPLS MN
55402

DANFORTH & ALLEN
731 NW BANK BLDG
MPLS MN
55402

DANKERS,KENNETH
1200 WEST FOURTH STREET
RED WING MN
55066

DAYTON CHAS SIERRA CLUB
400 ROANOKE
MPLS MN
55402

DIEHL JOHN
26 KENWOOD PKWY
ST PAUL MN
55105

DOUGLASS BELL
525 OSBORN BLDG
ST PAUL MN
55102

DOYTON MAURICE, MET SEWER BD
350 METRO SQ BLDG
ST PAUL MN
55101

EBELING EDWARD H.
161 W. MAIN
PERHAM MN
56573

ELDRED R W ARMOUR & CO
UNION STOCK YARDS
SO ST PAUL MN
55075

ELMER EDWIN W
2901 PLEASANT AVE
MPLS MN
55408

ENV SERV-GEN RESOURCE CORP
6340 INDUSTRIAL DR
HOPKINS MN
55343

ERDMAN ROGER TENNANT CO
701 N LILAC DR
MPLS MN
55441

EVANS CHAS.L. PRENTICE-HALL
ENGELWOOD CLIFFS
NEW JERSEY

EVERETT JERRY NW PETRO ASSN
512 NICOLLET MALL RM917
MPLS MN
55402

FAEGRE & BENSON ATTN LIBR
1260 NW BANK BLDG
MPLS MN
55402

FINNEGAN J.R.
55 E. 4TH
ST.PAUL MN
55101

FLEMING FREDERICK A
1860 HIGHLAND PARKWAY
ST PAUL MN
55116

MOOD R BLOOMINGTON HLTH DEPT
10200 PENN SO
BLOOMINGTON MN
55431

MOONEY, MICHAEL A.
BOX 903, ST.JOHN'S UNIV
COLLEGEVILLE MN
56321

NASS GEO V HENN CO GEN HOSP
5TH AND PORTLAND AVE
MPLS MN
55415

NATL CAR RENTAL ATT D MIT
5501 GREEN VALLEY DR
MPLS MN
55437

NAT'L SOLID WASTES-R. GRASSO
1730 RHODE ISLAND AV.NW
WASHINGTON DC
20036

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NEUMAN RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NIELSEN STOCK & BLACKBURN
415 730 BLDG
MPLS MN

NURSING HOME ADMRS BD EXAMRS
277 W UNIV AVE
ST PAUL MN
55103

NW BELL TEL CO LEGAL DEPT
224 S 5TH ST RM 2000
MPLS MN
55402

OCONNOR GREEN THOMAS ET AL
845 NW BANK BLDG
MPLS MN
55402

OFFICE OF THE GOVERNOR
130 STATE CAPITOL
ST PAUL MN
55101

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PETERSON GARY
854 MIDLAND BK BLDG
MPLS MN
55401

PHILLIPS LEGISLATIVE SERVICE
459 RICE ST
ST PAUL MN
55103

POPOVICH PETER S
314 MINN BLDG
ST PAUL MN
55101

POSS DONALD G
6301 SHINGLE CREEK PKWY
BROOKLYN CTR MN
55430

PRAUSE JOS.C.
2220 105TH AVE.N.W.
COON RAPIDS MN
55433

QUIRIN E W
336 STATE OFF BLDG
ST PAUL MN
55155

RED OWL STORES INC
215 E EXCELSIOR AVE
HOPKINS MN
55343

RENNER R.H. ST PAUL AREA
300 OSBORN BLDG.
ST PAUL MN
55102

RICHARDS MONTGOMERY ET AL
1430 RAND TOWER
MPLS MN
55402

ROBBIE JOSEPH
904 CARGILL BLDG NO CTR
MPLS MN
55402

SAN SIMEON DEVELOP CORP
OLD 1ST STATE BK BLDG
PAYNESVILLE MN

ST PAUL ASSN PLBG HTG MECH
614 AM NATL BK
ST PAUL MN

ST PAUL BUR HLTH DR P COX
555 CEDAR ST
ST PAUL MN
55101

SCHAPS NICHOLAS
100 DAIN TOWER
MPLS MN
55402

SCHMIDT D R MN ASSN REALT
6101 WAYZATA BLVD
MPLS MN
55416

SCHNEIDER MAHLON
GREEN GIANT
LESUEUR MN
56058

SCHWARTAU NEAL METH HOSP
201 W CENTER ST
ROCHESTER MN
55901

SCHNEIDER & NEESER
706 1ST ST SO PO BX 876
WILLMAR MN
56201

SCHROEDER ALFRED H
2172 CARROLL AVE
ST PAUL MN
55104

SENATE FINANCE COMMITTEE
113 STATE CAPITOL
ST PAUL MN
55101

SENATE GOV OP COMM
RM 303 STATE CAPITOL
ST PAUL MN
55155

SHELL OIL CO. W.A. ROQUET
ONE SHELL PLAZA BX 2463
HOUSTON TX
77001

SITE ENGINEERS INC
900 REDWELL LANE
APPLE VALLEY MN
55124

SLOCUM CHARLES A
1203 IDS TOWER
MPLS MN
55402

SMERIKA WN.
BOISE CASCADE PAPERS
INTL FALLS MN
56649

STATE BD.BARBER EXAMINERS
555 WABASHA
ST PAUL MN
55102

STATE BD VETERINARY EXAMI
C/O DR A C SPANNAUS DVM
WACONIA MN

STENSLAND M.E. PRES. MVMA
203 NW 22ND ST.
AUSTIN MN
55912

STOLPESTAD BROWN & SMITH
1550 NW BK BLDG
ST PAUL MN
55101

SUMMIT NATL BANK D L MORRILL
205 AURORA AVE
ST PAUL MN
55103

SUSSEL CO.ATTN:TED SCHWEN
1850 COMO AVE.
ST PAUL MN
55108

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIV
4901 W 77TH ST
MPLS MN
55435

MINN BD PODIATRY EXAM & REG.
1111 W 2ND ST.
CROOKSTON MN
56716

MINN COUNCIL STATE EMP NO
475 RICE ST
ST PAUL MN
55103

MINN ELECTRICAL ASSN INC
525 SO 7TH
MPLS MN
55415

MINN ENV CONTROL CITIZEN
CENTRAL MANOR 26 E EXCH
ST PAUL MN
55101

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN HEREFORD-LJ SCHAFER

BUFFALO LAKE MN
55314

MINN HOUSING INST N T CARTER
7801 METRO PKWY
MPLS MN
55420

MINN LAND USE COMMITTEE
4344 IDS CENTER
MPLS MN
55402

MINN.MTR.TRANSP. .J.N.DENN
1821 UNIV.
ST.PAUL MN
55104

MINN PETROLEUM COUNCIL
446 BUILDERS EXCH BLDG
MPLS MN
55402

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN 55
104

MINN SCH BUS OPERATORS ASSN

FARIBAULT MN
55021

MINN SOCIETY ARCHITECTS A
NW NATL BK BLDG
ST PAUL MN
55101

MINN ST BD PHAR P G GRUSSING
1965 FORD PKWY
ST PAUL MN
55116

MINN STATE CAPITOL EMP UN
PO BOX 3215
ST PAUL MN
55165

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN TEAMSTERS CREDIT UNI
2021 HENN AVE E
MPLS MN
55413

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN WATER RESOURCES BD
RM 206 555 WABASHA ST
ST PAUL MN
55102

SWEITZER R L HONEYWELL INC
2701 4TH AVE S
MPLS MN
55408

TIMESAVERS INC ATT R S VOLD
5270 HANSON COURT
MPLS MN
55422

TWIN CITY RETAIL DRUGGIST
2388 UNIV AVE
ST PAUL MN
55104

VAN CLEVE JOHN H
2101 HENN AVE
MPLS MN
55405

VERRILL JOHN E
DEPT SECONDARY ED UOF M
DULUTH MN
55812

VILLAGE OF WOODBURY-F.STR
561 TOWER DRIVE
NEWPORT MN
55055

WALTERS THOS H
4510 W 77TH ST STE 235
MPLS MN
55435

WEST MIDWAY-SO.ST ANTH.PK.AS
898 RAYMOND AVE.
ST PAUL MN
55114

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

WIS FEEDER PIG MARKET CO-OP

FRANCIS CREEK WI

WOLKERSTORTER THEODORE
676 17TH AVE NW
NEW BRIGHTON MN
55112

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS
COMMISSIONER OF
PUBLIC WELFARE

In the Matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

AFFIDAVIT OF MAILING

Rosie E. Krumrie, being first duly sworn, deposes and says:

That on the 14th day of June, 1974, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of St. Paul, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the attached Certificate of the Secretary of State as well as to all persons listed on the attached sheet as presently being members of the Minnesota Legislature.

Rosie E. Krumrie

Subscribed and sworn to before me
this day of July, 1974.

PATRICIA A. SCHULTZ
Notary Public, Dakota County, Minn.
My Commission Expires June 19, 1981

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS
COMMISSIONER OF PUBLIC WELFARE

In the matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

FINDINGS OF FACT

The above-entitled matter came on for hearing before the Deputy Commissioner of Public Welfare of the State of Minnesota on the 16th day of July, 1974, at 8:30 a.m., in the State Office Building Auditorium, Wabasha Street, St. Paul, Minnesota, after proper notice required by Minn. Stat. § 15.0412 (1971) was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced, and upon the records, files and proceedings herein, I find the following:

(1) Minn. Stat. § 256B.04, subd. 2 (1971) mandates that the Commissioner of Public Welfare promulgate rules and regulations in order to effectively implement the medical assistance program in Minnesota. DPW Rules 49 and 47 have been adopted and are hereby amended pursuant to that statutory authority.

(2) DPW Rule 49, which establishes the welfare per diem rates for nursing home providers, warrants amending due to the increased costs of owning and operating such a facility. The adopted amendments to DPW Rule 49 filed herewith are in recognition of and response to these escalating operational expenses.

(3) The amendments to DPW Rule 47 are hereby adopted in an effort to clarify existing inconsistencies and to instruct the county welfare agencies regarding the transfer of personal property as it affects eligibility for the medical assistance program in Minnesota.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner of the Minnesota
Department of Public Welfare

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS
COMMISSIONER OF PUBLIC WELFARE

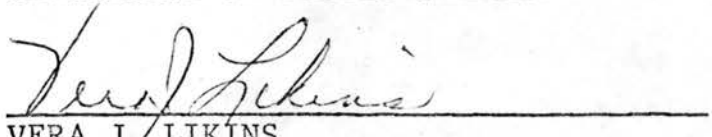
In the matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

STATEMENT OF NEED

The above-captioned rules are amendments to existing rules of the Minnesota Department of Public Welfare. The last time the above-captioned rules were amended was February 4, 1974 (DPW Rule 49), and August 15, 1972 (DPW Rule 47).

The need to adopt the amendments to DPW Rule 49 arises primarily because of the rising costs of staffing and operating nursing home facilities in the State of Minnesota. The need to adopt amendments to DPW Rule 47 arises because of the realization that more specific guidelines are needed by the county welfare agencies regarding the transfer of personal property and its effect on eligibility for Minnesota's medical assistance program.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE



VERA J. LIKINS
Commissioner of the Minnesota
Department of Public Welfare

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS
COMMISSIONER OF
PUBLIC WELFARE

In the Matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Public Welfare governing the administration of Per Diem Rates for Nursing Homes (Rule 49), and Eligibility for Medical Assistance (Rule 47).

ORDER ADOPTING RULES

The above-entitled matter came on for hearing before the Deputy Commissioner of Public Welfare of the State of Minnesota on the 16th day of July, 1974, at 8:30 a.m. in the State Office Building Auditorium, Wabasha Street, St. Paul, Minnesota, after proper notice required by Minn. Stat. § 15.0412 (1971) was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced and upon the records, files and proceedings herein, and applicable statutory standards or criteria, and having confirmed the need for the above-captioned rules.

NOW, THEREFORE, IT IS ORDERED that these rules identified as DPW Rule 49 and DPW Rule 47 are adopted this 6th day of November, 1974, pursuant to authority vested in me by Minn. Stat. § 256B.04, subd. 2 (1971).

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner of the Minnesota
Department of Public Welfare

PROPOSED

PROPOSED AMENDMENTS TO THE REGULATIONS OF THE MINNESOTA DEPARTMENT OF PUBLIC WELFARE FOR DETERMINING WELFARE PER DIEM RATES FOR NURSING HOME PROVIDERS UNDER THE TITLE XIX MEDICAL ASSISTANCE PROGRAM

DPW RULE 49

DPW 49 Regulations for Determining Welfare Per-Diem Rates for Nursing-Home Providers Under the Title XIX Medical Assistance Program.

4900 Applicability and Purpose

4901 Authority

This regulation is enacted pursuant to the statutory authority vested in the Commissioner of Public Welfare pursuant to Minnesota Statutes, Section 256b.27 to require reports, information and audits, and pursuant to Minnesota Statutes Section 256B.04, Subdivision 2, to promulgate rules and regulations for carrying out and enforcing the provisions of Minnesota Statutes, Chapter 256B. This regulation is further promulgated pursuant to the procedures set out in Minnesota Statutes, Section 15.0412, of the Minnesota Administrative Procedures Act.

4902 Objectives

The procedures embodied herein define a system for the determination of a per-diem welfare rate for all nursing homes participating in the Medical Assistance Program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these regulations if nursing-home patients account for 50 per cent of more of the facility population.

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

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

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

SECTION 4910 - RATE DETERMINATION

4911 Method of Calculating Per Diem Rate

a. Historical rate. The method of calculating the nursing-home provider per-diem rate for skilled, ICF I, and ICF II facilities will be to determine reasonable costs for the most current fiscal year and divide by adjusted patient days according to reasonable cost provisions of 4930 and cost-reporting regulations contained in 4920.

b. Incentive factor. In no case will the historical rate so determined under 4911a. be less than ~~a comparable amount~~ the historical rate calculated for the previous year minus one-half of the difference. This provision shall not

4911 apply for rates for newly established providers under 4913a., rates set by applying exceptions provided by 4939d. and flat rates established under 4913e. For multi-level providers this provision will be applied to the facilities average historical rate.

c. Allowance for known cost changes.

1. Future cost increases or decreases that are in accordance with the reasonable cost principles of ~~4913~~ 4931, known as of the report filing date, must be added to or deducted from the historical rate determined according to 4911a. and b. Such adjustment will be restricted to the elements defined in 4911c.1(a) through (h) and shall be the annualized cost effect of such cost changes exclusive of any portion of the cost change included in the historical rate.

(a) Salary and wage changes to occur during the effective period of the welfare rate:

(1) Future changes according to labor contracts, board resolutions, written policies, or minimum wage laws.

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

(3) The total facility salary and wage changes cannot exceed 6% of historical salaries exclusive of top management salaries without justification that the increment in excess of 6% is required to bring facility salaries to the salary range of comparable facilities.

(b) Changes in facilities.

(c) The annualized cost effect of complying with federal, state, or local laws and regulations and Department of Public Welfare announced policies on care or facilities.

(d) ~~Taxes---payroll-Payroll,-and-property-and-sales-taxes.~~ All taxes except for income taxes.

(e) Interest

(f) Depreciation

(g) Utilities

(h) Rental payments pursuant to a written lease.

(i) Raw food cost increase computed initially by multiplying $1.20 times one half the percentage increase in the wholesale price index for raw food during calendar 1973. The initial increase is 13.5¢. For reports covering periods ending December 31, 1974 or later, this known cost increase shall be calculated as follows :

(1) Calculate the percentage increase in the wholesale price index for raw food for the period December through November.

(2) If the increase is greater than that computed for the prior year, add the difference to (1).

(3) If the increase is less than that computed for the prior year, subtract the difference from (1).

(4) Multiply one half of the resulting figure times the sum of $1.20 plus the all annual increases allowed pursuant to this section.

(j) Unidentified cost increases equal to one per cent of the facility's historical cost portion of the welfare rate or one per cent of the regional (4914b.) average historical cost portion of the welfare rate, whichever is lower.

4911 2. Cost changes determined under this provision must be based upon facts and commitments in existence as of the original filing date of the report (4921e.1.). If the provider cannot substantiate that such facts and commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to 4912c. If known cost changes calculated under (a) through (h) above do not in fact occur, the welfare rate will similarly be subject to adjustment under 4912c. If actual cost increases exceed the known cost changes determined under (a) through ~~(h)~~ (i) above, no adjustment in welfare rate will be made.

4912 Effective date, notifications and adjustments.

a. Effective date. A new per-diem rate determined by the Department will be effective the first day of the month following the provider's normal fiscal year-end except in instances in which penalty provisions of regulation 4921f. are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. ~~Notification of rate decision.~~ A temporary rate notification consisting of the previous year's allowed historical cost per patient day plus 80% of the indicated allowed known cost changes per patient day will be issued and paid on receipt of the report. ~~and effective according to 4912a.~~ The Commissioner will notify the provider in writing and the respective county welfare boards of the final rate determined under these regulations ~~as well as~~ and the effective date of such rate. Included in this notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

c. Adjustments for errors or omissions. All rates determined according to DPW Rule 49 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by 4921j. Such adjustments are limited to the three complete fiscal years preceding the date an audit commences. If the adjustment results in a payment from the provider to the county welfare board(s), the provider will have up to 120 days from the date the provider receives written notification of the adjustment. If the adjustment results in a payment ~~from the county welfare board(s)~~ to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

4913 Special Rate Setting Procedures

a. Newly constructed facilities

1. Required reports. Providers with newly constructed facilities may request an interim welfare rate. Providers who increase the facility's capacity by at least 50% may at their option be considered in this classification. The provider must submit reports as required in 4921a. for the immediate future fiscal year forecast results.

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

3. Interim rate establishment. The Commissioner will establish an interim rate in accordance with regulations 4911 retroactive to the first day a Medical Assistance recipient is placed in the home. Such rate shall be subject to retroactive upward or downward adjustment in accordance with all provisions of DPW Rule 49 except Section 4911b. on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with 4912a and 4921j.

4913 b. Rates for lesser care levels in facilities without certification classification. Providers who provide care to welfare recipients requiring less care than the care level to which the provider is certified will receive a per diem rate as follows:

1. ICF I care per diem rate in a skilled nursing-care facility will not exceed 85 per cent of the established skilled nursing-care rate for that facility.
2. ICF II care per diem rate in an ICF I facility will not exceed 60 per cent of the established ICF I rate for that facility.
3. ICF II care per diem rate in a skilled nursing-care facility will not exceed 50 per cent of the established skilled nursing-care rate for that facility.

This provision shall be applied in conjunction with 4923c.2.

c. Private room rate. A private room rate of 115 per cent of the established welfare per diem rate for the applicable care level in an individual home shall be allowed for a Medical Assistance recipient when deemed a medical or other necessity for the individual patient or as the patient's condition affects others; such condition must be determined by the attending physician and approved by the county welfare board. This provision, together with the provisions of 4939b. shall apply only to facilities applying for a Certificate of Need after August 15, 1972.

d. Care classification additions. Providers who add certified care classifications may file an amended report under 4921 that includes known cost changes associated with care classification additions to obtain a welfare per diem rate for care not previously provided. At the provider's option he may accept the lesser care rates under 4913b. in lieu of filing reports according to this provision.

e. Election of flat rate for small providers. Providers with a capacity of less than 30 licensed beds may annually elect to receive a flat per diem rate for providing required care of welfare patients by filing a flat rate report in lieu of receiving a rate complying with reporting requirements of 4921 and otherwise being subject to provisions of DPW Rule 40. The flat rate for skilled, ICF I, and ICF II for each region or group of regions as defined in 4914b. shall be ~~75 per cent of~~ the regional average rates as determined from ~~based on~~ filed reports before the maximum rate limitation and excluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins.

Such an election must be filed within reporting deadline provided by 4921e, or be subject to penalty provisions of 4921f. Such rates elected by providers will be in effect for one year.

f. Incidental welfare rate. Providers may elect to receive a flat rate under 4913e for care of welfare recipients if welfare recipients account for less than twenty per cent of the certified capacity of the home.

4914 Rate Limitations

a. Limitation based on private pay rates or relevant federal or state laws and regulations. Notwithstanding any other provisions of these regulations, the established provider rates for nursing-home care will not exceed the normal provider's rate charged private patients for comparable nursing-care services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited to federal laws or regulations that affect the Medical Assistance Program.

4914 b. Maximum rate. Individual welfare rates will be subject to a maximum of 125 per cent of regional average costs plus known cost changes exclusive of this limitation and ~~exclusive of~~ flat rates under 4913e. Regions will be those areas designated by the Governor for regional planning and economic-development purposes. Regions may be combined when deemed appropriate by the Commissioner as announced through policy bulletins. The regional averages will be calculated separately for proprietary, and non-proprietary and hospital-attached facilities except the regional average costs for hospital-attached facilities shall be included in the regional average calculation for non-proprietary free-standing facilities. The maximum-rate limitations will be adjusted annually through policy bulletins. The regional averages will be determined by the Commissioner, using all available information from reports that indicate a fiscal-year end during a calendar year and will be applied to rates that become effective during the second succeeding calendar year. Facilities that have a non-calendar-year end and have been previously subject to the maximum rates may adjust the rates to the new maximum rates if previously justified by the reports.

c. Maximum rate exceptions.

1. Welfare per diem rates in excess of the maximum rate limitation will be allowed in the initial year to the extent that the welfare rate requested includes cost increases required to increase wages to the minimum standards of federal or state wage laws.
2. Provision 4914b. will not apply to homes that qualify for exception under 4939d.3.
3. Provision 4914b. will not apply to providers with newly constructed facilities or providers who increase the facility's capacity by 50% for the first two immediate fiscal years.
4. Welfare per diem rates in excess of the maximum rate limitation will be allowed to the extent of 85 per cent of the first $2.00 per patient day over the maximum welfare rate when total allowable costs are divided by actual patient days or 93 per cent of total capacity patient days, whichever is greater.

d. Minimum rate. The minimum welfare per diem rates will be 75 per cent of the regional average as defined in 4914b.

4915 Appeal Procedures

a. Scope of appeals procedures. These procedures describe the manner by which unresolved individual provider or county welfare board disputes that may arise concerning application of these regulations excluding regulation 4915 will be settled. Unresolved disputes are defined as those disagreements which cannot be resolved informally between the provider and the Department staff normally assigned responsibility for administration, or the provider and a county welfare board.

b. Composition of appeals committee. Unresolved disputes will be heard by ~~a~~ an ~~seven-man~~ appeals committee composed of nine members. ~~knowledgeable and interested people.~~ No more than three persons representing nursing homes or nursing home associations shall serve at any one time. The Commissioner shall consult with various professional organizations and select the members of the appeals committee for terms not to exceed his own term of appointment.

c. Compensation of committee members. ~~M~~embers of the Appeals Committee shall be compensated for time and expenses incurred in performance of required duties.

d. Frequency of committee meetings and hearings. The Appeals Committee will meet at least quarterly at a predetermined time and place to hear and determine dispute

4915 e. Time limit. The provider, or the county, has 30 days to appeal from the date of the Department's notification of the new per diem rate.

f. Appeals procedure. If the provider and the Department's staff normally assigned responsibility for the administration or the provider and a county welfare board cannot agree to a settlement of the dispute, then each party will submit in writing the facts, arguments and any other appropriate data to the Appeals Committee~~.~~ ~~Committee days of the dispute and may require frequent additional information~~ or analyses to be submitted by the Department or the provider, and then recommend to the Commissioner disposition of the dispute. Because existing state law does not permit the Commissioner to delegate his powers, final authority on disposition of disputes must be retained by the Commissioner. Unless otherwise agreed to by the parties, neither the Department nor the provider may introduce exhibits at the appeal hearing unless a copy has been provided to the other party at least 14 days prior to the hearing date or five days after receipt of an exhibit from the other party if it is in direct response to the exhibit received from the other party.

g. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the ~~amount in dispute~~ new per diem rate will prevail ~~not be adjusted~~ until final determination according to these appeal procedures is made. The total dollar amount due the provider or the county resulting from the resolved disputes will be subject to payment provision of 4912c.

h. Findings and conclusions. Any data, findings, conclusions, or opinions of the Appeals Committee and any department data in regard to any provider appeal will be made available to the provider and will become part of the Department record. The Department will prepare quarterly a summary of the decisions of the Appeals Committee rendered during the preceding quarter.

SECTION 4920 - REPORTS

4921 General Reporting Requirements and Submittal Procedures.

a. Required Reports. Except as provided by 4913e. and f., to receive a per diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the Department. Reports, supporting documentation, and worksheets will consist of the following:

1. General provider information and statistical data.
2. Financial statements consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations.
3. Reports of historical costs and known cost changes together with supporting calculations and worksheets.
4. Rate-determination worksheets.
5. Other relevant data may be required by the Commissioner to support a welfare rate request. If such data are not provided within 30 days, the Commissioner must calculate a rate, making whatever assumptions deemed appropriate to arrive at the rate in the absence of the requested data.
6. A complete statement of fees and charges.
7. The names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten per cent or more of the facility.

4921 Specific report formats and preparation instructions will be contained in a provider manual prepared and revised periodically by Department personnel. Copies of said manual will be made available to all interested parties through the Documents Section of the Department of Administration. Newly established providers or providers who change their fiscal year must file short-period reports if the period covered is more than five months.

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

c. Records. The provider, where applicable, will maintain statistical and accounting records to support information in no less detail than that required by 4921a. required reports. The provider shall also make available federal and state income tax returns upon request of Department personnel.

d. Report certification.

1. Reports required in regulation 4921a. will be accompanied by a certification of (1) the majority owner defined as the person having over 50 per cent effective ownership, or the chief financial officer if there is no majority owner, and (2) the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.
2. If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitted as a part of reports required by 4921a.

e. Reporting deadlines and extensions.

1. Deadlines. Required reports shall be submitted directly to the Department within three calendar months after the close of the provider's normal fiscal year.
2. Report deadline exceptions. The Commissioner may grant exceptions to the reporting deadline for just cause. A routine extension of 60 days will be granted when a written request is received by the Department prior to the reporting deadline.

Penalties.

1. Report preparation and submittal. The penalty for non-compliance with Regulation 4921a and 4921e. will be to reduce the reimbursement rate to 80 per cent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the Commissioner.
2. False reports. Incorrect or false information supplied by the provider on required reports resulting in overpayments to the provider will result in one or more of the following :
   (a) Immediate adjustment of the welfare rate, along with retroactive recovery by the county welfare board of funds incorrectly paid to the provider.
   (b) Termination of the provider contractual agreement.
   (c) Prosecution under applicable federal and Minnesota statutes.

4921 g. Audits. All reports will be subjected to desk audit and may be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider record keeping and accounting practices, the Commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of 4921f.1. or 2. may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by 4921a. must be prepared in accordance with reasonable cost principles in Section 4930.

~~j.~~ i. Amended reports. Except as provided in 4911c.2., providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage law changes occur unexpectedly. The cost change omissions to comply with minimum wage law changes will be limited to the wage increases required to meet the minimum standards of federal or state wage laws. Such changes in the welfare per diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less, for each annual period. The payment and period covered by this provision are governed by 4912c.

4922 Special Provisions for Multi-home Providers and Providers Involved in Other Business Activities.

a. Reporting exceptions. Providers who operate several homes or who are engaged in activities other than nursing care may not be able to comply with the required reports referred to in 4921a. In that case, the provider must indicate reasons for noncompliance.

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

c. Cost allocation of top-management salaries and management fees. The allocated portion of compensation for the chairman of the board, directors, presidents, or other similarly titled individuals allocated to an individual nursing home shall be subject to the limitation provided in regulation 4933a. Other corporate charges or costs allocated to a nursing home must represent the cost of services actually rendered and be identified as to the type of service proviced.

4923 Definitions

a. Care definitions. The following care classifications are used in cost reporting required by these regulations. The definitions of these terms included in DPW Rule 47 and appropriate federal regulations governing Title XIX are hereby adopted.

1. Skilled Nursing Home (Skilled)
2. Intermediate-Care Facility I (ICF I)
3. Intermediate-Care Facility II (ICF II)

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

4923

1. Nursing - All directly identifiable costs associated with nursing care defined in Section 4923a. In general, these include bedside care; administration of medications, irrigations, and catheterizations; application of medications, dressings, or bandages; rehabilitative nursing techniques; and definition of modified diets, as well as other treatments prescribed by a physician that require professional or technical knowledge, skills, and judgment as possessed by a professional nurse. Included are comfort medications, medical supplies, devices, and other routine supplies not separately reimbursed as listed in Regulation 4923b.8. Personnel costs to be included in nursing are the salaries of the director of nursing, supervising nurses, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants (ICF II care only). The salaries or fees of physicians performing consulting services not reimbursed by separate fee schedule are also to be included in this cost category.
2. Dietary - All directly identifiable costs of normal and special diet food including food preparation and serving. Personnel costs to be included in dietary are the salaries of dieticians, chefs, cooks, dishwashers, and all other employees assigned t the kitchen and dining room.
3. Laundry and linen - All directly identifiable costs of linen and bedding, laundering, and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, seamstresses, laundrymen, and ironers.
4. Housekeeping - All directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, maids, and other cleaning personnel.
5. Plant operation and maintenance - All directly identifiable costs for maintenance and operation of he buildings and grounds, including fuel, electricity, water, supplies and parts to repair and maintain equipment and facilities, and tools, Personnel costs to be included are the salaries of engineers, painters, hearing-plant employees, plumbers, electricians, carpenters, and watchmen.
6. Other care-related services - All directly identifiable costs of other services, such as recreational activities, religion, rehabilitation, arts and crafts, and social services.
7. General and administration - All directly identifiable costs for administering over-all activities of the facility, including business-office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefit costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified under definitions in 4923b.
8. Miscellaneous nonreimbursable services and expenses -
   (a) All directly identifiable costs of functions normally reimbursed by charges to patients, employees, or outsiders, such as the operating costs of a pharmacy, beauty shop, or coffee and gift shop are included here.
   (b) Also included are specific costs that may be incurred by the provider and reimbursed separately according to a fee schedule. These include but are not limited to the following:
      1. Services provided by licensed medical, therapeutic, or rehabilitative practitioners.
      2. Oxygen at prevailing prices.
      3. Wheel-chair alterations for specific Medical Assistance recipients.

4923 (c) Also included in this section will be costs associated with operating activities financed by gifts or grants from private or public funds.

(d) All costs classified in 4923b.8. are not allowable for purposes of determining a per diem rate under these regulations.

c. Patient days.

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

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

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

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

4924 Cost Allocation Procedures

a. General provisions for all providers.

1. Costs will be classified in accordance with categories defined in Regulation 4923b. and, if applicable, by care level defined in Regulation 4923a.

2. Classification of costs to cost categories 4923b. will involve one or more of the following steps:

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

(b) In instances in which individuals have multiple duties, the person's salary cost will be allocated to categories 4923b. on the basis of management's estimate of time spent on various activities. This procedure will not be applied to administrators or other chief executives' salaries in facilities with 60 or more licensed beds.

(c) Other costs that cannot be classified to cost categories through use of procedure 4924a.2.(a) and 4924a.2.(b) will be classified in the administrative category.

3. Adjustments for costs otherwise reimbursed. Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in regulation 4923b.8.

4. Non-allowable cost adjustments. Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in Section 4930 of these regulations. All adjustments will be footnoted with the applicable regulation number. Costs previously excluded by 4923b.8. will not require further adjustment.

b. Specific care level allocation procedures for multi-level providers. Cost allocation procedures are necessary to determine costs among different care level facilities. Allocation procedures are defined in the following sections and will be applied in the order stated except where noted otherwise. Regardless of method selected, a reasonable identification of costs to care level must result.

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1. Nursing care - Any combination of allocation procedures (a), (b), and (c) below can be used as long as the result is a reasonable approximation of actual costs incurred by care level.
   (a) Direct identification (without allocation) in the routine classification of transactions when costs are recorded in the books and records of the provider (e.g. invoice and time record account classifications).
   (b) Cost allocation on the basis of regularly validated time or cost studies.
   (c) Remaining costs (e.g. nursing supervisor, supplies, etc.) not classified under methods (a) or (b) above will be allocated on the ratio of costs identified to care levels (using (a) and/or (b) above), one care level to another.
   (d) If methods (a), (b), or (c) above cannot be used, costs will be allocated on the basis of actual patient days weighted by the ratio of maximum allowable nursing care and attendant hours as defined in regulation 4932.
2. Dietary.
   (a) Cost allocation on the basis of regularly validated time or cost studies.
   (b) Cost allocation based on the number of meals served.
   (c) Cost allocation based on the actual patient days.
3. Laundry and linen, housekeeping, and plant operation and maintenance. The following allocation procedures can be applied to individual department costs or the combination of these three departments at the option of the provider.
   (a) Same as 4924b.1.(b) - time or cost studies.
   (b) Allocation on the ratio of square feet of floor space devoted directly to each care level.
   (c) Same as 4924b.2.(c) - patient days.
4. Other care related services
   (a) Same as 4924b.1.(b) - time or cost study
   (b) Same as 4924b.2.(c) - patient days
5. General and administration - Cost allocation on the ratio of the combined cost by care level determined for categories 4924b.1. through 4. and 6.
6. Depreciation, interest and real estate and personal property taxes
   (a) Location of equipment when determinable.
(b)
   (b) Same as 4924b.3.(b) - square feet.
   (c) Same as 4924b.2.(c) - patient days. This allocation procedure must be used if actual patient days in any care level exceeds certified capacity patient days.
7. Earnings allowance - Cost allocation on the ratio of the combined cost by care level determined for categories 4924b.1. through 4. and 6.

c. Hospital attached facilities. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups:
   1. All expense classifications without depreciation, administration and general.
   2. Depreciation.
   3. Administration and general.

SECTION 4930 - REASONABLE COST PRINCIPLES

4931 General Provisions

a. Reasonable costs. Costs to be allowable for rate setting purposes must satisfy the following over-all criteria:
   1. They must be necessary and ordinary costs related to patient care.
   2. They must be costs that prudent and cost-conscious management would pay for a given item or service.

4931 b. Costs not allowable Costs that relate to management inefficiency, unnecessary care or facilities, and activities not common and accepted in the nursing care field are not allowable.

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

d. Substance over form. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in DPW Rule 49 will be disallowed under the principle that the substance of the transaction shall prevail over form.

e. Costs due to changes in federal or state requirements. Costs incurred to comply with changes in federal or state laws and regulations on increased care and improved facilities are allowable costs for purposes of determining a historical per-diem rate under 4911a.

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

g. Annual review of cost limitations. The Commissioner shall review annually the dollar limitations for top management compensation limitation (4933a.) and depreciation basis limitation (4934b.) and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

h. Application of principles and specific limits. The reasonable cost principles defined in 4931 apply to all reported costs and have been specifically defined for certain cost elements in 4932 through 4939.

4932 Nursing Care and Attendant Limitations

a. Nursing care. Nursing-care costs will be limited by a maximum number of nursing hours per patient day as follows:

Skilled - 2.9 hours
ICF I - 2.3 hours

If the actual average nursing hours per patient day exceed the above limit, the reasonable cost limitation will be calculated by multiplying the ratio of the above stated limit to the average actual nursing hours per patient day for the year times the actual cost per patient day. This limitation will not apply to facilities that qualify for exception under 4939d.3.

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

4933 General and Administrative Expenses

Reasonable cost criteria for general and administrative expenses are as follows:

4933 a. Top-management compensation limitation. Top-management compensation includes that of owners, administrators, president, chairman of the board, board members, or other individuals receiving compensation as executives but not performing duties of a department head. Compensation includes the costs of non-cash compensation such as residences, salaries, and deferred compensation except IRS qualified pension or profit sharing plans. The average annual cost limitation for rate-setting purposes on compensation is determined according to the average number of combined licensed nursing-home and boarding-care beds according to the following schedule:

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

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

b. Assistant Administrator. Reasonable compensation of assistant administrators is not subject to the limitation in 4933a.

c. Other management services. The costs of other directors' fees, unidentified management fees, and physician compensation for performing administrative functions are allowable to the extent that such costs together with compensation of top management do not exceed the limitations defined in 4933a.

d. Other general and administrative costs.

1. Owners life insurance. The costs of premiums are not allowable.
2. Personal expenses. Personal expenses of owners or employees, such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation do not exceed the limitations of 4931c. and 4933a.
3. Professional, technical, or business-related organizations. These costs are allowable if their function and purposes can be reasonably related to the development and operation of nursing facilities, patient-care facilities, and programs for the rendering of patient-care services.
4. Social, fraternal, and other organizations. Costs incurred in connection with memberships in all organizations not included in 4933d.3. are not allowable.
5. Travel and automobile. These expenses are not an allowable expense unless they are related to activities of managing the nursing home.
6. Entertainment. These expenses are not allowable costs.
7. Advertising. Costs incurred in connection with maintaining or maximizing occupancy are allowable.
8. Pension and profit-sharing plans. Contributions to either an Internal Revenue Service approved pension or profit-sharing plan, but not both, are allowable costs.
9. Employee education costs, orientation, and on-the-job training. Costs relating to providing improved patient care or, where required by state

4933 law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories, 4923b. unless not identifiable.

10. Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.
11. Telephone, television, and radio service. These are allowable costs where furnished to the general patient population in areas of provider day rooms, recreation rooms, lounges, etc. The cost of these services when located in a patient accommodation is not allowable.
12. Noncompetitive agreement. Costs of these agreements are not allowable.
13. Pre-opening costs. One time pre-opening costs of new facilities incurred prior to admittance of patients must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period no less than 120 consecutive months beginning with the month in which the first patient is admitted for care. Examples of these costs are wages paid prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.
14. Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.
15. Fund-raising costs. Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by 4936a.
16. Charitable contributions. These are not allowable costs.

4934 Depreciation

a. Basis for depreciation calculation.

1. Cost. Historical cost of nursing facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 4934a.2.
2. Change in ownership of facilities. In a case in which a change in ownership of a nursing-home facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:
   (a) In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of :
      (1) The portion of the purchase price properly allocable to depreciable nursing home facilities; or
      (2) The appraised value of the depreciable nursing home facilities calculated under the reproduction cost, depreciated method.
   (b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of 4934a.2.(a) the case of a complete change in ownership except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 per cent. Any increase allowed by this section will then be adjusted according to Section 4934a.6.
3. Redemption of ownership interests. In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying the provision of 4934a.2.(b
4. Donated assets. The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price

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that an able buyer would pay a willing seller in an arms-length sale or appraised value defined in 4934a.2.(a)(2), whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

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

6. Recapture of depreciation resulting from sale of facility. The sale of depreciable nursing-home property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation calculated in accordance with 4934 indicates the fact that depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation.

   a. The amount of the recapture will be determined as follows:

      (1) The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after the effective date of DPW Rule 49 (November 1, 1972).

      (2) The gross recapture amount as determined in (1) above shall be allocated to fiscal periods from November 1, 1972, through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under DPW Rule 49. The amount allocated to each period shall be divided by the total actual patient days in that period, thereby determining a patient-day cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the patient-day cost for each fiscal period.

      (3) The total net recapture amount determined according to (2) above will be reduced by one per cent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the State of Minnesota is includable in the new owners' basis for depreciation subject to the provisions of 4934a.2.

   b. The net recapture amount so determined in (3) above will be paid by the new owner to the State of Minnesota within a time period agreed to by the Commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

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

b. Limitations.

1. The total basis of depreciable nursing-facility assets shall not exceed an average of ~~$11,000~~ $13,000 per bed for licensed beds in two or more beds per room and ~~$16,500~~ $19,500 per bed for licensed private rooms built after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975 according to the construction index for the previous 12 months. The depreciable basis for licensed beds built prior to January 1, 1974 shall not exceed an average of $11,000 per

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bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private rooms which satisfy the certificate of need provision of 4913c. The depreciable basis for licensed private rooms built prior to August 15, 1972 shall not exceed an average of $16,500 per bed for a maximum of 5% of licensed beds.

2. In no instance can accumulated depreciation calculated in accordance with 4934 exceed the basis defined in Section 4934a.
3. Accumulated depreciation as of the beginning of the first fiscal year covered by this regulation shall be calculated retroactively using the useful life concept defined in Sections 4934c. and 4934d.
4. Regardless of the applicability of the limitation stated in 4934b.1. above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by ~~state or federal~~ governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under Section 4934a. applying one of the "useful life" schedules defined in Section 4934c.1. or 4934c.2.

1. Building - 35 years
   Major building improvements (depreciated over the remaining life of the principal asset or useful life, but not less than 15 years).
   Land improvements - 20 years
   Equipment - 10 years
   Vehicle - 4 years
2. American Hospital Association depreciation guidelines.

d. Other useful lives

1. Depreciation rates for used facilities and equipment. The useful life shall be assigned by the provider considering the individual circumstances; however, the useful life will not be shorter than one-half of the useful life provided by Sections 4934c.1. or 4934c.2.
2. Leasehold improvements. The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

e. Depreciation method. The straight-line method of depreciation should be used except, at the option of hte provider when the principal payments on capital indebtedness (as defined in Section 4936a.1.) exceed the total depreciation allowance calculated in accordance with Section 4934. In such instances, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and six years for equipment. Accumulated depreciation cannot exceed the basis defined in Section 4934a.

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

g. Non-depreciable assets. Nurisng-facility assets that are not depreciable include but are not restricted to:

1. Land. Includes the land owned and used in provider operations included in the cost of land and the costs of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature.
2. Goodwill. Includes amounts that result from purchase of property or stock in excess of determinable value as determined in 4934a.2.

4934 h. Capitalization vs. Expense. Expenditures for equipment that has a useful life of more than one year shall be capitalized except that the provider may show as expenses small equipment purchases normally capitalized if such items do not exceed two cents per patient-day annually.

4935 Leased Facilities or Equipment

a. Rental charges. Rental charges incurred by a provider through a lease entered into an arm's-length transaction are fully includable as allowable costs.

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

c. Rental charges incurred on leases entered into before the effective date of these regulations are includable as allowable costs except as provided in part d.

~~c~~ d. Limitation. Allowable rental charges are subject to the investment per bed limitations of 4936a.1.(a) determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of Federal Hospital Insurance Fund obligations as of the effective date of the lease. The formula for determination of this provision ~~will be included in the provider Manual~~ is as follows:

Present value of lease = Lease payment per period x present value factor per period

Investment per bed = Present value of lease - Licensed Beds

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

4936 Cost of Capital

a. Interest

1. Interest expense is an allowable cost and will be classified as follows:
   (a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any load that is applied to purchase fixed assets related to providing nursing care as defined in 4936b.1.(a). The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.
   (b) Other interest for working capital and operating needs that directly relate to providing nursing care is an allowable cost. The form of indebtedness will include, but not be limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.
2. Interest income will be a deduction from interest allowable under provision 4936a.1.(a) or 4936a.1.(b). Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpended donated funds carried by the institution that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

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

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

5. Allowable interest limitation for proprietary providers. Because of the provision of 4936b. for proprietary providers, the allowable interest expense defined in Section 4936a.1.(a) shall not exceed the providers average interest rate, times 65 per cent of net allowable assets as defined in 4936b.1.(a).

b. Earnings Allowance for Proprietary Providers

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

   (a) Net allowable fixed assets employed will include actual cost of land, land improvements, buildings and equipment, less cumulative depreciation calculated in accordance with regulation 4934 and further limited to $1,000 in excess of the limitations provided in 4934b.1.

   (b) The amount of capital provided by owners will be assumed to be 35 per cent of net allowable fixed assets employed in providing nursing care.

   (c) The after-tax rate of return allowed on capital provided by owners, calculated on the basis of 4936b.1.(a) and 4936b.1.(b), will be ten per cent.

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

   (e) An additional earnings allowance will be allowed on the remaining 65 per cent of net allowable fixed assets not otherwise covered by capital indebtedness. The allowance will be 6 per cent of this amount.

~~c. Leased facilities. An earnings allowance to a proprietary provider who has a leased facility will be permitted to the extent that the provider can substantiate the fact that the calculated earnings of the lessee and lesser combined do not exceed the earnings allowance provided by 4936.~~

~~d.~~c. Minimum cost of capital allowance ~~for all providers~~. Notwithstanding the provision of 4936a.5. and 4936b., the cost of capital allowance shall be no less than the combination of:

1. Actual interest on capital indebtedness, and
2. An earnings amount determined by multiplying 93 per cent of capacity patient days for a fiscal year, or part thereof if a short period report is being filed, by thirty-five cents.

4936 ~~c.~~d. Minimum cost of capital allowance for non-proprietary providers and non-proprietary leased facilities. The cost of capital allowance for non-proprietary providers and leased facilities determined in ~~4936d.2.~~ 4936c.2. shall be reduced by the per-diem effect of facility utilization incentives under 4939a.

e. Minimum cost of capital allowance for proprietary leased facilities. The minimum cost of capital allowance for proprietary leased facilities determined in 4936c. and the facility utilization incentive determined in 4939a. will not exceed the aggregate cost per patient day of seventy-five cents plus disallowed interest.

4937 Welfare

All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patient exclusively will be calculated in a manner that results in an assignment of the incremental costs stated above wholly to welfare patients. Such costs may include reasonable expenditures for utilization review, preparation and processing of a cost statement under these regulations (limited to $500 for each reporting period on actual cost whichever is less), interest payments on federal or state loans taken to purchase or remodel equipment required for federal certification if it is clearly shown that these expenditures are associated exclusively with the welfare program and benefit welfare patient exclusively.

4939 Facility Utilization Incentives

a. Capacity limitation. The allowable cost amount per patient day for depreciation, interest, property taxes, administration and earnings allowance will be calculated by dividing such allowable costs by 93 per cent of total capacity patient days for licensed beds. Facilities qualifying for the special care rates of 4923c.2. may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 per cent of total capacity patient days for licensed beds.

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

c. Licensed bed capacity. Useable or operable bed capacity may be used for purposes of the calculation required by 4939a. and b. if the provider can justify in writing, to the satisfaction of the Commissioner that licensed beds is an appropriate measure of capacity.

d. Waiver of limitation. Providers may apply for a waiver of the provisions of 4939a. and b. in the following instances:

1. For new facilities or facilities with major changes in capacity, that are applying for a certificate of need after the effective date of these regulations, the Commissioner may grant a waiver of this capacity calculation and allow a rate based on anticipated actual patient days for the period through the end of the first full fiscal year.
2. In cases of extreme hardship, nursing homes not covered by 4939d.1. and having over 65 per cent welfare patient days may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. "Extreme hardship" will include a financial situation in which projected cash flow indicates the fact that debt and operating obligations cannot be met.
3. ~~Facilities~~ Skilled care facilities which have a patient population ~~in a care level~~ with an annual average length of stay of 180 days or less.

SECTION 4950 - IMPLEMENTATION PROCEDURES

4951 Effective Date of DPW Rule 49 Revisions

a. All revisions of this revised DPW Rule 49 shall take effect beginning with reports covering fiscal years ending after May 31, ~~1973~~ 1974.

~~b. Providers may file no later than October 31, 1973, a revised or amended report to take into account the revised rule. The revised rate so determined shall be effective as of July 1, 1973.~~

Estimated Useful Life of Land Improvements, Buildings, and Fixed Equipment

Land Improvements

Item	*Years*
Fencing	
Brick or stone	25
Chain link	20
Wire	10
Wood	15
Flagpoles	20
Paving (including roadways, walks, and parking)	
Asphalt	10
Concrete	25
Gravel	15
Retaining walls	25
Shrubs, lawns, and trees	10
Signs	10
Underground sewer and water lines	20
Yard lighting	20

Buildings

Boiler houses	30
Garages	
Masonry	25
Wood frame	15
Masonry, reinforced concrete frame	40
Masonry, steel frame (fireproofed)	40
Masonry, wood frame	30
Residences	
Masonry	30
Wood frame	25
Storage buildings	20

Fixed Equipment

Building Services Equipment

Central television antenna systems	10
Clock systems	15
Electric lighting and power feed wiring	20
Conduit and wiring	20
Fixtures	15
Switch gear	20
Transformers	20
Elevators	
Dumbwaiter	20
Freight	20
Passenger, high speed, automatic	20
Passenger, other	20
Heating, ventilating, and air conditioning systems	20
Air conditioning systems (all equipment and units)	
Large—over 20 tons	15
Medium—5 to 15 tons	12
Small—under 5 tons	8
Boilers	20
Compressors, air, under 5 HP	15
Compressors, air, 7½ HP and over	15
Condensate tanks	20
Condensers	15
Controls	20
Coolers and dehumidifiers	15
Cooling towers	
Metal	15
Wood	15
Duct work	20
Fans, air handling and ventilating	15
Filters	15
Furnaces, domestic type	20
Incinerator, indoor	20
Oil storage tanks	20
Piping	20
Precipitators	15
Pumps	15
Radiators, cast iron	25
Radiators, finned tube	20
Unit heaters	15
Nurse call systems	20
Oxygen, gas, air piping	20
Paging systems	15
Plumbing, composite	20
Fixtures	20
Piping	25
Pumps	15
Water heaters	15
Water storage tanks	20
Sewerage, composite	25
Piping	25
Sump pumps and sewerage ejectors	15
Sprinkler and fire protection systems	20
Fire alarm systems	20
Fire pumps	20
Sprinkler system	25
Tanks and towers	20
Telephone systems	20
Vacuum cleaning system	20

Other Fixed Equipment

Built-in benches, bins, cabinets, counters, shelving	20
Conveying systems	15
Generator sets	25
Hoods, fume	20
Sinks and drainboards	20
Sterilizers (built-in)	20

Estimated Useful Lives of Individual Items of Major Movable Equipment

Item	*Years*
Accounting/bookkeeping machines	8
Adding machines	10
Addressographs	15
Air conditioners (window)	10
Ambulance	4
Analyzers, gas	10
Anesthesia units	15
Audiometers	10
Auto-analyzers	10
Autoclaves	20
Automobiles, delivery	4
Automobiles, passenger	4
Autoscalers, ionic	10

Item	Years
Bain Maries	15
Balances	15
Basal metabolism units	10
Bassinets, heated	10
Baths, paraffin	15
Baths, water, laboratory	15
Beds, electric	15
Beds, manual	15
Benches, metal, wood	20
Bins, metal, wood	20
Biochemical analysis units, micro	10
Blanket dryers	15
Blanket warmers	15
Bleach tanks	15
Blood clot timer units	15
Blood counters	15
Blood processing units	10
Boilers, copper	15
Bottle washers	10
Breathing units, positive pressure	10
Broilers	10
Buffer, electric	10
Cabinets, metal and wood	20
Cabinets, solution	15
Calculators	10
Cameras	8
Canopies, ventilating, ironer	20
Cardiographs	10
Cardioscopes	10
Carts, food/tray, heat-refrig.	10
Cash registers	10
Cassette changers	15
Centrifuges	15
Chairs, dental	15
Chairs, metal and wood	20
Chairs, specialist	15
Chairs, wheel	15
Check protectors	10
Chloridometer-titrators, automatic	12
Chromatographs, gas	10
Cobalt, radioactive	5
Coffee grinders	10
Coldpack units, floor	12
Collators, electric	12
Collectors, silver, automatic	15
Colorimeters	10
Compressors, air	15
Cookers, pressure, food	10
Cookers, starch	20
Coolers, walk-in, free standing	20
Copiers	10
Counters, food service	15
Counters, radiation	10
Croupettes	10
Crushers, syringe	10
Cutters, cloth, electric	10
Cutters, food	10
Defibrillators	10
Dental treatment units	15
Desks, metal and wood	20
Diathermy units	10
Dictating equipment	10
Dish sterilizers	10
Dishwashers	10
Disinfectors	15
Distilling apparatus	20
Driers, clothes	15
Driers, hair	10
Driers, sonic	10
Drills, press	15
Drying ovens, paint shop	15
Duplicators	15
Electrocardiographs	10
Electroencephalographs	10
Electrophoresis units	10
Electrosurgical units	10
Emery wheels, electric	15
Examining tables, metal and wood	20
Extractors, laundry	15
Floor scrubbing machines	7
Floor waxing machines	7
Fluoroscopes	10
Folders, flatwork	15
Food choppers	12
Frames, turning	15
Fryer, deep fat	10
Furnaces, laboratory	20
Glove conditioners	10
Glove driers	10
Glove powdering machines	10
Glove testers	10
Graphotypes	15
Griddles	10
Grinder bench	15
Grinder, coffee	10
High frequency apparatus with diathermy	10
Homogenizers	15
Hubbard tanks	15
Hydrocollators, floor	12
Ice cream freezers	10
Ice cream storage cabinets	10
Ice cube making equipment	10
Illuminator units, multifilm	15
Incubators	15
Incubators, laboratory	15
Ironers, flatwork	15
Jointer/planers, electric	15
Kettle, steam jacketed	10
Kilns	10
Kymographs	10
Ladders	10
Lamps, deep therapy	10
Lamps, emergency	15
Lamps, infrared	10
Lamps, mercury quartz	10
Lathes	20
Lawnmowers, power	4
Lights, delivery	15
Lights, examining	10
Lights, operating	15
Lights, portable, emergency	20
Linen markers	15
Linen tables	15
Loaf molding equipment	10
Looms	15

Item	Years
Mailing machines	12
Marking machines	15
Meat choppers	10
Meters, pH	10
Microfilm units	15
Microprojectors	20
Microscopes	15
Mixers, commercial type	15
Oscilloscopes	15
Oven, baking	15
Oven, paraffin	10
Oven, roasting	15
Ovens, sterilizing	10
Oxygen tents, motors, and trucks	10
Paint spray booth	15
Paint spraying machines	15
Paper balers	20
Peelers, potato	15
Peelers, vegetable	15
Photometers	10
Photrometers	10
Physicians' in-and-out registers (portable)	15
Pianos	15
Planers and shapers, electric	15
Polishers, floor	10
Polishing and buffing machines	10
Presses, laundry	15
Projection machines	15
Pulmotors	10
Pumps, vacuum and pressure	15
Radiographic-fluoroscopic combination	10
Refrigerators, commercial type	12
Respirators	10
Respirometers	10
Resuscitators	10
Rinsers, sonic	10
Saws, bench, electric	21
Scales, counter, platform, postal	10
Scales, laundry	20
Scanners, isotope	10
Scintillation scalers	10
Seriographs, automatic	10
Serological baths	15
Sewing machines	15
Shaking machines	10
Sharpeners, microtome knife	15
Shears, squaring, floor	20
Slicers, bread	10
Slicers, meat	10
Snow blowers	10
Spectrometers	10
Spectrophotometers	10
Steamer, vegetable	10
Sterilizers, movable	20
Stoves	15
Stoves, heating	10
Suction pump	10
Tables, autopsy	20
Tables, examining	15
Tables, metal and wood	20
Tables, obstetrical	20
Tables, operating	20
Tables, refrigerated	12
Tables, therapy	15
Tanks, hot water	15
Tanks, paraffin	15
Tanks, soap	15
Tents, oxygen	10
Time recording equipment	10
Tissue processors	10
Toasters, commercial type	10
Tractors	10
Transcribing equipment	10
Tray conveyors	15
Trucks, hot food	10
Tumblers	15
Typewriter, electric	5
Typewriter, manual	8
Ultraviolet units	15
Urns, coffee	10
Urns, milk	10
Vacuum cleaners	10
Ventilating fans	15
Vibrators	10
Volumetric, blood gas apparatus	10
Waffle irons, commercial type	10
Wall washing	10
Warmers, dish	15
Warmers, food	15
Washing machines, commercial type	15
Water baths	15
Water coolers—bottle type, fountain type	10
Water purifiers and softeners	15
Whirlpool baths	15
X-ray developing tanks	10
X-ray film driers	10
X-ray film processors	10
X-ray machines, deep therapy	10
X-ray machines, mobile	10
X-ray machines, superficial therapy	10

PROPOSED AMENDMENTS TO THE

REGULATIONS

OF THE

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

RELATING TO THE

TRANSFER OF PROPERTY

UNDER THE

MEDICAL ASSISTANCE PROGRAM

DPW RULE 47

(r) Property Transfers. If a Medical Assistant applicant or recipient transfers any real or personal property without receiving a reasonable consideration therefor, he shall be presumed to have done so to become or remain eligible for Medical Assistance or to have deprived himself or his spouse of a resource that could have been used to meet his or their current needs if (a) the transfer occurred while he was receiving Medical Assistance or three years prior to the date of his application therefor, and (b) the value of the property so transferred exceeded the statutory limits established for Medical Assistance eligibility.

The applicant or recipient has the burden of overcoming this presumption to the satisfaction of the county welfare agency. If he fails to do so, he shall be ineligible for Medical Assistance for a period beginning with the date of the transfer and ending with the date on which his medical needs (incurred since the date of the transfer) exceed the amount of his equity in the property so transferred in excess of the statutory limits.

~~(r)~~ (s) General Administration. These rules and regulations shall be binding upon the county in the administration of the Program.

Effective Date - _____