

Minnesota Attorney General: Administrative Rules Proceedings

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Paul G. Zerby
Deputy Attorney General

August 3, 1977

- Amendments to Rule 49 - Welfare Per Diem Rates for Nursing Home Providers

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

July 20, 1977

Michael B. Miller, Special Assistant Attorney General
Administration Building - Room G-19
St. Paul, Minnesota 55155

Re: In the Matter of the Amendments to Rule 49 of the Minnesota Department of Public Welfare

Dear Mr. Miller:

I am resubmitting to you the official file on the above-entitled matter based on the deletion of those rules which you identified in your June 13, 1977 memorandum as being unacceptable for rule promulgation. The changes which I have made on this resubmittal of the rule can be found in the following sections and on the indicated pages of Exhibit C:

Section B.4.b. - page 5 - I have deleted the proposed maximum rate provision and have replaced it with the existing provision as promulgated in the September 1, 1974 version of the rule.

Section C.1.a.(8) - page 7 - I have deleted the proposed provision requiring audited financial statements.

Section D.5.b.(3) - page 21 - I have deleted the proposed provision defining the allowable rental fee.

Section D.8.a. - page 23 - I have deleted the proposed capacity limitation and have replaced it with the existing provision as promulgated in the September 1, 1974 version of the rule.

I would request that you review this version of the rule as to form and legality and, if acceptable, I would further request that this rule be then filed with the Secretary of State.

If there are any questions in regard to this matter, I can be contacted at 6-2738.

Very truly yours,

Robert J. Rau, Director
Audit Division

RJR/jb

AN EQUAL OPPORTUNITY EMPLOYER

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE EDWARD J. DIRKSWAGER, JR.

ACTING COMMISSIONER OF PUBLIC WELFARE

In the Matter of the Proposed Amendment to Rule 49 of the Minnesota Department of Public Welfare

REVISED ORDER ADOPTING RULES

The above mentioned matter came on for hearing before Mr. Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner on November 12, and 13, 1976 at the Minnesota State Office Building after proper notice as required by Minnesota Statutes Section 15.0412 was served on all persons, associations and other interested groups registered with the Secretary of State for that purpose.

At said hearing proposed amendments to Mn. Rule DPW Rule 49 were considered as originally proposed and shown in the attached Exhibit A hereto. The following persons appeared for the Department of Public Welfare (DPW); James Hiniker, Deputy Commissioner; Thomas Fabel, Deputy Attorney General, and Richard Tester, Auditor. Ninety-one persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard. Based upon the proceedings as indicated in the Report of Hearing Examiner dated January 25, 1977, a copy of which is attached as Exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minnesota Statutes § 15.0412 subd. 4(1976) said Report was available to all affected persons for over ten days subsequent to the date of the Report.

By Order Adopting Rules dated March 30, 1977 and Revised Order Adopting Rules dated May 31, 1977 the former Commissioner Vera J. Likins adopted, rejected, and made findings in lieu of certain parts of the Reports of the Hearing Examiner and Chief Hearing Examiner.

After affording interested persons an opportunity to present written and oral statements, having reviewed all of the testimony, having considered all of the evidence adduced, having considered the Reports of the Hearing Examiner and of the Chief Hearing Examiner and upon all the proceedings and testimony herein and applicable statutory standards or criteria, and having determined the need for the above captioned rules and the reasonableness thereof.

NOW, THEREFORE, IT IS ORDERED that the Acting Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner dated January 25, 1977 to the following extent:

1. Findings of Fact of the Hearing Examiner 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 17, 19, 20, 22, (except that "temporary rate" shall be substituted for "interim rate" on the third line from the bottom of page 12), 23, 24, 25, 26, 27, 28, 29, 31 (with the exception of the Examiner's comments on the constitutionality of the provision in question therein), 32, 33, 34, 35, 36 37, 38, 40, 43, 45, 46, 47, 48 and 49 are adopted and incorporated in full except as otherwise noted in parentheses.

2. Findings of Fact 11 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

In her Order of March 30, 1977 Adopting Rules the former Commissioner adopted Finding of Fact of the Hearing Examiner 11 "(except that regional maximums do include unidentified cost increases)". In the Report of the Chief Hearing Examiner, paragraph 4, page 2, it is asserted that this amended Finding 11 is contrary to DPW's Testimony at the hearing citing T.59. The Report of the Chief Hearing Examiner continues a misunderstanding contained in the Hearing Examiner's original Finding 11. The current Rule 49 contains a formula for calculating "unidentified cost increases" - B.1.(j). That formula allows unidentified cost increases equal to one percent of the facility's historical cost or one percent of the regional average of historical cost, whichever is lower. The proposed rule changes this to substitute a cost index percentage times a home's historical costs for which a specific known cost change is not required or claimed. At the hearing Mr. Brose asked Mr. Hiniker if DPW were going to limit the new unknown cost allowance by applying the regional average limitation in the current rule. Mr. Hiniker answered "no" - (T.59). The Hearing Examiner misunderstood this exchange, thinking Mr. Brose and Mr. Hiniker were discussing "regional maximums" when in fact, as the transcript

shows, they were discussing the regional averages.

3. Findings of Fact of the Hearing Examiner 16, 18, 21, and 44 are accepted and the proposed provisions of the rule affected by these findings are withdrawn pending further support of evidence through the hearing process.

4. Finding of Fact 30 of the Hearing Examiner is rejected and the proposed provision of the rule affected by this finding is withdrawn as being an unnecessary statutory repetition.

5. Findings of Fact 39 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

Minn. Stat. § 256B.42, subd. 2, defines "facility" as:

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

In the proposed rule DPW restated the statutory definition but modified the last sentence to read "Facility does not include the land or any supplies and equipment not permanently attached to it". However, DPW did not propose a definition of fixture although it did state that its interpretation would allow only fixtures which are physically attached to the building (T.231-233). The Hearing Examiner, in finding 39, suggested that DPW adopt a definition tendered by the MAHCF. In the proposed rule as initially adopted DPW rejected their suggestion and adopted a definition favored by DPW. The Chief Hearing Examiners Report Finding 11, states that the definition cannot be adopted because it is not based on facts and arguments presented at the hearing. While the Chief Hearing Examiner's conclusion in this regard is subject to challenge (see T.29, 42-44, 47, 221 and 231-235) DPW now withdraws the definition and deletes it from the Revised Adopted Rule leaving the matter to be decided under the statute on a case-by case basis under the language of the statute.

6. Findings of Fact 41 and 42 of the Hearing Examiner are rejected.

7. The following additional Finding of Fact 50 is made:

Senator Milton testified (T.20-22).

> I am a State Senator from District 49. I was appointed Chairman of the Senate Select Committee on Nursing Homes in February of 1975 and asked to take on responsiblity to investigate nursing home businesses in the State of Minnesota, both from the point of view of quality care as well as alleged misuse of the Medicaid system.
>
> I think for the purpose of this particular hearing we are interested in the later and not the former, and everybody who is interested in the Final Report of that Committee that met jointly with the House for a period of about a year, is welcome to a copy of the Report, including the previous speaker, and my telephone number is 296-4168, and we have ample copies available to clearly express what the legislative intent was.
>
> During that time I chaired each of the meetings jointly with Representative Jim Swanson from Richfield, who was the Chairman of the like committee from the House, and also acted to a great extent as the director of the research efforts on the part of the staff, which consisted of joint House-Senate staff as well as Senate staff in making our investigation.
>
> I would like to begin my comments by saying that in my judgement, having reviewed the proposed Rule in detail, having read it completely twice, and having reviewed it with the staff that drafted the legislation, that did the interviews, developed the Findings and presented the material then to the authors of the bills that provided the committees with all of their information as well as recommendations on amendments to the original bills that were drafted, that participated in the conference committees, the judgement of that staff that supported me in reviewing this proposed Rule, in my judgement the proposed Rule does clearly carry out the intent of the law.

There are a couple of questions that I had that I met with Mr. Hiniker earlier on and asked him about, and have been further clarified, and at this point I would say that what you have before you is a very accurate, a very conscientious and a very deliberate attempt on the part of the executive agency to carry out the intent of the legislature.

8. The following additional Finding of Fact 51 is made:

It was and is the intent of the Department that the provisions of Rule 49 shall be severable. If any provisions of the Rule are found to be unreasonable or not supported by the evidence, it is the intent of the Department that the remaining provisions shall remain valid.

9. Conclusions 1, 2 and 3 of the Hearing Examiners are adopted and incorporated in full provided that the reference in Conclusion 3 to Findings shall be deemed to refer to Findings as set forth in this Order.

10. Recommendations 1 and 2 of the Hearing Examiner are adopted and incorporated herein provided that the reference in Recommendation to Findings and proposed rules shall be deemed to refer to Findings and proposed rules as set forth in this Order.

IT IS FURTHER ORDERED that the Acting Commissioner hereby adopts the proposed amendment to Rule 49 of the Minnesota Department of Public Welfare so that from and after this day of July 20, 1977, said Rule 49 shall read in its entirety as set forth in the attached Exhibit C hereto, pursuant to the authority vested in me pursuant to Minnesota Statutes, Chapters 15, 246, 253A, 256 and 257. To the extent inconsistent herewith the Acting Commissioner hereby recinds the previous Order Adopting Rules dated March 30, 1977 and Revised Order Adopting Rules dated May 31, 1977.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Edward J. Dirkswager Jr.

EDWARD J. DIRKSWAGER, JR.
ACTING COMMISSIONER

317A

Attorney General

Paul G. Zerby
Deputy Attorney General
Department of Welfare

July 7, 1977

Michael B. Miller
Special Assistant
Attorney General

296-4692

Department of Welfare Rule 49

In my memorandum of June 13, 1977, which gives the reasons for return of the above-captioned rule to your department, there are two mistakes: 49D.5.b.(3): The reason for rejection of this rule should be that it is a statutory repetition. 49D.6.b.(1): rejection of this rule was a mistake based upon mis-reading of the rules. This rule is proper as to form and legality, and may be included with the rules upon resubmission.

MBM:mb

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO 317A : Paul G. Zerby
Deputy Attorney General
Department of Welfare

DATE: June 13, 1977

FROM : Michael B. Miller
Special Assistant
Attorney General

PHONE: 296-4692

SUBJECT: Department of Welfare Rule 49

The above-captioned rule is returned herewith, and has not been filed with the Secretary of State. The reasons for return of the rule to the Department of Public Welfare are as follows:

49B.4.	This rule was not supported by substantial evidence at the hearing.
49C.1.a.(8)	This rule is rejected as being overly broad.
49D.5.b.(3)	This rule is rejected as being an unnecessary statutory petition.
49D.6.b.(1)	This rule was not supported by substantial evidence at the public hearing.
49D.8.a	This rule was not supported by substantial evidence at the hearing.

Please call me if you wish to discuss these rules in further detail.

MBM:mb

Enclosure

cc: John M. Broeker

Corrected Copy

Exhibit F

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

Revised January 1, 1977

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

A. Applicability and Purpose

1. 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.

2. Objectives

The procedures embodied herein define a system for the determination of per-diem welfare rate for all nursing homes participating in the Medical Assistance Program and board and care licensed facilities participating in the Minnesota Supplemental Aid Program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these 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 include 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.

B. RATE DETERMINATION

1. 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 D. and cost-reporting regulations contained in C.

b. Incentive factor. In no case will the historical rate so determined under B.1.a. be less than the historical rate calculated for the previous year minus one-half of the difference. This provision shall not apply for rates for newly established providers under B.3.a. rates set be applying exceptions provided by D.8.d. and flat rates established under B.3.e. 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 D.1. known as of the report filing date, must be added to or deducted from the historical rate determined according to B.1.a. and b. Such adjustment will be restricted to the elements defined in B.1.c.(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:

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

(ii) 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) 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 cost increase shall be calculated as follows:

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

(ii) If the increase is greater than that computed for the prior year, add the difference to (i)

(iii) If the increase is less than that computed for the prior year, substract the difference from (i).

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

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

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 C.1.c.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 B.2.c. 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 B.2.c. If actual cost increases exceed the known cost changes determined under (a) through (i) above, no adjustment in welfare rate will be made.

2. 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 C.1.f. are applicable. If the new rate results in a lower rate than the provious 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. 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 temporary rate shall be limited by all maximums contained in Rule 49. Individual as well as overall maximums apply. The Commissioner will notify the provider in writing and the respective county welfare boards of the final rate determined under these regulations and the effective date of such rate. Included inthe 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 C.1.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 to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

3. 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 C.1.a for the immediate future fiscal year forcast 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 reason why the provider cannot comply.

(3) Interim rate establishment. The Commissioner will establish an interim rate in accordance with regulations B.1 retroactive to the first day a Medical Assistance recipient is placed in the home. Such rate shall be

B.1.b

subject to retroactive upward or downward adjustment in accordance with all provisions of DPW Rule 49 except B.1.b. 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 B.2.a. and C.1.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 except that facilities whose skilled rates are affected by B.4.c.(1) shall receive up to 85% of what their skilled rate would have been without application of B.4.c.(1).

(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 C.3.c.(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 D.8.d. 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 C.1. 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 B.3.b. 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 C.1. 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 B.4.b. shall be the regional average rates as determined from filed reports before the maximum rate limitation and excluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins.

Such an election must be filed within reporting deadline provided by C.1.e. or be subject to penalty provisions of C.1.f. 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 B.3.e. for care of welfare recipients if welfare recipients account for less than twenty per cent of the certified capacity of the home.

4. 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. Notwithstanding any other section of the rule which establishes allowable costs, welfare rates for each level of care in individual facilities will be subject to separate overall limitations on the cost for items which directly relate to the provision of patient care to residents of nursing homes and those which do not directly relate to the provision of care. The initial overall limitations will be calculated on the basis of 125 per cent of regional average costs plus known cost changes in each of these categories exclusive of these limitations and flat rates under B.3.c. Cost of depreciation, real estate taxes, investment or capital allowance, interest, rent, and those costs reported as general administration on Rule 49 cost reports shall be included in the maximum relative indirect costs. All other costs items are included in the direct care maximum calculations. However, in calculating overall limitations, the Commissioner shall include without adjustment actual costs for depreciation, real estate taxes, investment or incentive allowances, rent, interest and those costs reported as general administration on Rule 49 cost reports. Separate rate limits will be calculated for regions 11 and 3 as if they were one region and for all other regions as if they were one region. Regions will be those areas designated by the Governor for regional planning and economic-development purposes. The regional averages will be calculated separately for proprietary, non-proprietary and hospital-attached facilities except the regional average cost 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 effective January 1 of each year as 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 which have been previously subject to the maximum rates may adjust rates to the new maximum rates upon computation of new maximum rates each year, if justified by cost reports previously filed.

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 B.4.b. will not apply to homes that qualify for exception under B.8.i.(3) or facilities licensed under DPW Rule 80.

(3) Provision B.4.b. 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) A welfare per diem rate componant in excess of either of the maximum rate limitations contained in B.4.b. 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 provided that in no event shall this section affect a per diem rate by more than $1.70.

(5) Provision B.4.b. 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 B.4.b.

5. 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 B.5. 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. Time Limit. The provider, or the county, has 30 days to appeal from the date of the Department's notification of the new per diem rate. Appeals will be heard by a Hearing Examiner of the Office of Hearing Examiners and will be according to rules of that office in addition to the provision of this rule.

c. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the new per diem rate will prevail until final determination according to these appeal procedures is made. The total dollar amount due the provider or the Department resulting from the resolved disputes will be subject to payment prevision of B.2.c.

C. REPORTS

1. General Reporting Requirements and Submittal Procedures.

a. Required Reports. Except as provided by B.3.e. 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.
(8) A separate audited balance sheet and statement of revenues and expenses for each nursing home owned by the same owner is required.

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 C.1.a. 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 C.1.a. 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 C.1.a.

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. A final rate will be established within 30 days of receipt by the Department of complete and accurate reports and required documentary information.

(2) Inadequate reports. The Department may reject any report that is incomplete or inaccurate within 30 days of receipt. In such case, the Department will establish a temporary rate in accordance with B.2.b. to be paid until the information is completely and accurately filed.

(3) Report deadlines 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 C.1.a. and C.1.e. 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 C.1.f.(1) or (2) may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by C.1.a. must be prepared in accordance with reasonable cost principles in Section D.

i. Amended reports. Except as provided in B.1.c.(2) providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage laws changes occur unexpectedly or when long term labor contracts expire and are renegotiated subsequent to the reporting deadline in C.1.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 B.2.c.

2. 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 C.1.a. 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 chairmen 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 D.3.a. 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.

3. 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 C.3.a. 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 C.3.b.(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 C.3.b.

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:

(i) Services provided by licensed medical, therapeutic, or rehabilitative practitioners.

(ii) Oxygen at prevailing prices.

(iii) 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 C.3.b.(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.

4. Cost Allocation Procedures

a. General provisions for all providers.

(1) Costs will be classified in accordance with categories defined in Regulation C.3.b. and, if applicable, by care level defined in Regulation C.3.a.

(2) Classification of costs to cost categories C.3.b 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 C.3.b 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 C.4.a.(2)(a) and C.4.a.(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 C.3.b.(8).

(4) Non-allowable cost adjustments. Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in Section D of these regulations. All adjustments will be footnoted with the applicable regulation number. Costs previously excluded by C.3.b.(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 D.2.

(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 C.4.b.(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 C.4.b.(1)(c) - patient days.

(4) Other care related services
(a) Same as C.4.b.(1)(b) time or cost study
(b) Same as C.4.b.(1)(c) patient days

(5) General and administration - Cost allocation on the ratio of the combined cost by care level determined for categories C.4.b.(1) through (4) and (6).

(6) Depreciation, interest and real estate and personal property taxes
(a) Location of equipment when determinable.
(b) Same as C.4.b.(3)(b) square feet.
(c) Same as C.4.b.(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 C.4.b.(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.

D. REASONABLE COST PRINCIPLES

1. 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.

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 B.1.a.

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 D.3.a. and depreciation basis limitation D.4.b. 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 D.1. apply to all reported costs and have been specifically defined for certain cost elements in D.2. through D.8.

2. 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 D.8.d.(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.

3. 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

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

b. Assistant Administrator. Reasonable compensation of assistant administrators is not subject to the limitation in D.3.a.

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 D.3.a.

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 D.1.c. and D.3.a.

(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 D.8.d.(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) Pension and profit-sharing plans. Contributions to either an Internal Revenue Service approved pension or profit-sharing plan, but not both, are allowable costs.

(8) 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, C.3.b. unless not identifiable.

(9) Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.

(10) 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.

(11) Noncompetitive agreement. Costs of these agreements are not allowable.

(12) 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.

(13) Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.

(14) 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 D.6.a.

(15) Charitable contributions. These are not allowable costs.

(16) As provided in Minn. Stat. §256B.47, Subd. 2, the following shall not be recognized as allowable costs:

(a) Political contributions.

(b) Salaries or expenses of a lobbyist as defined in M.S.10A.01, Subd. 11, for lobbying activities.

(c) Advertising designed to encourage potential residents to select a particular home.

(d) Assessments levied by the Health Department for uncorrected violations.

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

(f) Dues paid to a nursing home or hospital association.

4. 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 D.4.a.(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:

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

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

(b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of D.4.a.(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 D.4.a.(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 D.4.a.(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 D.4.a.(2)(a)(ii) 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 D.4. 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:

(i) 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).

(ii) The gross recapture amount as determined in (i) 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.

(iii) The total net recapture amount determined according to (ii) 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 D.4.a.(2).

(b) The net recapture amount so determined in (iii) 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. 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 $13,000 per bed for licensed beds in two or more beds per room and $19,500 per bed for licensed private rooms built or purchased after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975 according to a construction index as determined by the Commissioner. The depreciable basis for licensed beds built or purchased prior to January 1, 1974 shall not exceed an average of $11,000 per bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private room which satisfy the certificate of need provision of B.3.c. 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.

(2) In no instance can accumulated depreciation calculated in accordance with D.4. exceed the basis defined in Section D.4.a.

(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 D.4.c. and D.4.d.

(4) Regardless of the applicability of the limitation stated in D.4.b.(1) above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under Section D.4.a. applying one of the "useful life" schedules defined in Section D.4.c.(1) or D.4.c.(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 D.4.c.(1) or D.4.c.(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 D.6.a.(1).) exceed the total depreciation allowance calculated in accordance with Section D.4. 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 D.4.a. Depreciation on any new construction or expansion of facilities commenced on or after January 1, 1977, other than governmentally owned facilities, shall be on a basis of not less than 30 years. For facilities constructed or expanded prior to January 1, 1977, and for facilities purchased after January 1, 1977, presently existing depreciation rules will apply.

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. Nursing -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 D.4.a.(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.

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	15
Gravel	5
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 Fired 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
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Calculators	10
Cameras	8
Canopies, ventilating, ironer	20
Cardiographs	10
Cardioscopes	10
Carts, food/tray, heat-refrig.	10
Cash registers	10
Cassette changers	15
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Chairs, dental	15
Chairs, metal and wood	20
Chairs, specialist	15
Chairs, wheel	15
Check protectors	10
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Collators, electric	12
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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
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Dish sterilizers	10
Dishwashers	10
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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
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Emery wheels, electric	15
Examining tables, metal and wood	20
Extractors, laundry	15
Floor scrubbing machines	7
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Fluoroscopes	10
Folders, flatwork	15
Food choppers	12
Frames, turning	15
Fryer, deep fat	10
Furnaces, laboratory	20
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Glove driers	10
Glove powdering machines	10
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Griddles	10
Grinder bench	15
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Homogenizers	15
Hubbard tanks	15
Hydrocollators, floor	12
Ice cream freezers	10
Ice cream storage cabinets	10
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Incubators, laboratory	15
Ironers, flatwork	15
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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
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Marking machines	15
Meat choppers	10
Meters, pH	10
Microfilm units	15
Microprojectors	20
Microscopes	15
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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	15
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
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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

5. 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 D.5.a.(1) or (2) exists, the provisions of D.5.b. 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.

(3) The rental fee is in excess of the total amount it would pay to the owner of the facility as interest, investment allowance and depreciation. In these cases, the allowed rental amount will be limited to the amount that would be paid the owner for interest, investment allowance and depreciation.

c. Limitation. Allowable rental charges are subject to the investment per bed limitations of D.6.b.(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 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.

6. Cost of Capital

a. Interest

(1) Except as provided in Section D.6.a.(6) interest is an allowable cost for non-proprietary facilities only and will be classified as follows:

(a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchase fixed assets related to providing nursing care as defined in D.6.b.(1) The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

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

(2) Interest income will be a deduction from interest allowable under provision D.6.a.(1)(a) or D.6.a.(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) After the first three years that a non-proprietary or governmentally owned nursing home has been owned by its current owners, the state agency shall not recognize as an allowable cost the expense of interest on net debt for any indebtedness and loans which exceed 100 percent of the net asset value of the facility.

(6) A proprietary nursing home which pays interest on capital indebtedness at an interest rate in excess of nine percent may be reimbursed for one-half of its interest expenses in excess of the nine percent up to 12 percent if (a) the proceeds of the indebtedness are used for the purchase or operation of the nursing home and (b) the interest rate is not in excess of what a borrower would have had to pay in an arms-length transaction at the time the loan was made.

b. Investment allowance.

(1). Determination of allowance. Proprietary homes where cost reports are received after January 1, 1977, shall receive an investment allowance of nine per cent of the original value of the facility for depreciation purposes. Non-proprietary homes whose fiscal year begins after June 30, 1977, shall receive an investment allowance of two per cent of the original value.

(2) For purposes of this section the following terms shall have the meaning given to them.

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

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

7. Welfare
All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patientsexclusively 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.

8. Facility Utilization Incentives

a. Capacity limitations. The allowable cost amount per patient day for depreciation, interest, property taxes, administration, investment allowance, and capital allowance, shall in the case of non-proprietary homes be divided by ninety-three per cent of total capacity patient days for licensed beds and for proprietary facilities shall be divided by ninety-three per cent of total capacity patient days for licensed beds or actual patient days, whichever is greater. If the allowance in D.6.b. is permitted by federal regulation for non-proprietary nursing homes, then the allowance cost amount per patient day for the depreciation, interest, property taxes, administration, investment allowance for non-proprietary nursing homes shall be divided by ninety-three per cent total capacity patient day for licensed beds or actual patient days, whichever is greater.

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 D.8.a 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 D.8.a. and b. in the following instances:

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(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 D.8.d.(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) Skilled care facilities which have a patient population with an average length of stay of 180 days or less may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. The average length of stay is determined by dividing the actual patient days for the historical fiscal year by the total discharges for the historical fiscal year.

E. IMPLEMENTATION PROCEDURES

1. Effective Date of DPW Rule 49 Revisions

a. Unless noted otherwise, all changes are effective for rates set for cost reports received by the Department of Public Welfare after January 1, 1977. Changes in the cost-of-capital allowance for non-proprietary facilities other than non-proprietary lease facilities are effective July 1, 1977.

F. SEVERABLE PROVISIONS

1. If any provisions of the rule as adopted by Commissioner of Public Welfare are found to be unreasonable or not supported by the evidence, the remaining provisons shall remain valid.

EXHIBIT C

ADOPTED RULE
(7-20-77)

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

Revised January 1, 1977

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

A. Applicability and Purpose

1. 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.

2. Objectives

The procedures embodied herein define a system for the determination of per-diem welfare rate for all nursing homes participating in the Medical Assistance Program and board and care licensed facilities participating in the Minnesota Supplemental Aid Program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these 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 include 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 accountabili 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.

B. RATE DETERMINATION

1. 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 D. and cost-reporting regulations contained in C.

b. Incentive factor. In no case will the historical rate so determined under B.1.a. be less than the historical rate calculated for the previous year minus one-half of the difference. This provision shall not apply for rates for newly established providers under B.3.a. rates set be applying exceptions provided by D.8.d. and flat rates established under B.3.e. 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 D.1. knowmas of the report filing date, must be added to or deducted from the historical rate determined according to B.1.a. and b. Such adjustment will be restricted to the elements defined in B.1.c.(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:

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

(ii) 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) 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 cost increase shall be calculated as follows:

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

(ii) If the increase is greater than that computed for the prior year, add the difference to (i)

(iii) If the increase is less than that computed for the prior year, substract the difference from (i).

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

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

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 C.1.c.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 B.2.c. 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 B.2.c. If actual cost increases exceed the known cost changes determined under (a) through (i) above, no adjustment in welfare rate will be made.

2. 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 C.1.f. are applicable. If the new rate results in a lower rate than the provious 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. 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 temporary rate shall be limited by all maximums contained in Rule 49. Individual as well as overall maximums apply. The Commissioner will notify the provider in writing and the respective county welfare boards of the final rate determined under these regulations and the effective date of such rate. Included inthe 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 C.1.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 to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

3. 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 C.1.a for the immediate future fiscal year forcast 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 reason why the provider cannot comply.

(3) Interim rate establishment. The Commissioner will establish an interim rate in accordance with regulations B.1. 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 B.1.b. 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 B.2.a. and C.1.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 except that facilities whose skilled rates are affected by B.4.c.(1) shall receive up to 85% of what their skilled rate would have been without application of B.4.c.(1).

(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 C.3.c.(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 D.8.d. 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 C.1. 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 B.3.b. 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 C.1. 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 B.4.b. shall be the regional average rates as determined from filed reports before the maximum rate limitation and excluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins.

Such an election must be filed within reporting deadline provided by C.1.e. or be subject to penalty provisions of C.1.f. 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 B.3.e. for care of welfare recipients if welfare recipients account for less than twenty per cent of the certified capacity of the home.

4. 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 flat rates under II.C.5. 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, 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 B.4.b. will not apply to homes that qualify for exception under B.8.i.(3) or facilities licensed under DPW Rule 80.

(3) Provision B.4.b. 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) A welfare per diem rate componant in excess of either of the maximum rate limitations contained in B.4.b. 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 provided that in no event shall this section affect a per diem rate by more than $1.70.

(5) Provision B.4.b. 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 B.4.b.

5. 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 B.5., 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. Time Limit. The provider, or the county, has 30 days to appeal from the date of the Department's notification of the new per diem rate. Appeals will be heard by a Hearing Examiner of the Office of Hearing Examiners and will be according to rules of that office in addition to the provision of this rule.

c. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the new per diem rate will prevail until final determination according to these appeal procedures is made. The total dollar amount due the provider or the Department resulting from the resolved disputes will be subject to payment provision of B.2.c.

C. REPORTS

1. General Reporting Requirements and Submittal Procedures.

a. Required Reports. Except as provided by B.3.e. 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 C.1.a. 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 C.1.a. 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 C.1.a.

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. A final rate will be established within 30 days of receipt by the Department of complete and accurate reports and required documentary information.

(2) Inadequate reports. The Department may reject any report that is incomplete or inaccurate within 30 days of receipt. In such case, the Department will establish a temporary rate in accordance with B.2.b. to be paid until the information is completely and accurately filed.

(3) Report deadlines exceptions. The Commissioner may grant exceptions to the reportin 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 C.1.a. and C.1.e. 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 C.1.f.(1) or (2) may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by C.1.a. must be prepared in accordance with reasonable cost principles in Section D.

i. Amended reports. Except as provided in B.1.c.(2) providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage laws changes occur unexpectedly or when long term labor contracts expire and are renegotiated subsequent to the reporting deadline in C.1.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 B.2.c.

2. 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 C.1.a. 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 D.3.a. 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.

3. 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 C.3.a. 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 C.3.b.(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 C.3.b.

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:

(i) Services provided by licensed medical, therapeutic, or rehabilitative practitioners.

(ii) Oxygen at prevailing prices.

(iii) 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 C.3.b.(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.

4. Cost Allocation Procedures

a. General provisions for all providers.

(1) Costs will be classified in accordance with categories defined in Regulation C.3.b. and, if applicable, by care level defined in Regulation C.3.a.

(2) Classification of costs to cost categories C.3.b, 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 C.3.b 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 C.4.a.(2)(a) and C.4.a.(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 C.3.b.(8).

(4) Non-allowable cost adjustments. Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in Section D of these regulations. All adjustments will be footnoted with the applicable regulation number. Costs previously excluded by C.3.b.(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 D.2.

(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 C.4.b.(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 C.4.b.(1)(c) - patient days.

(4) Other care related services
(a) Same as C.4.b.(1)(b) time or cost study
(b) Same as C.4.b.(1)(c) patient days

(5) General and administration - Cost allocation on the ratio of the combined cost by care level determined for categories C.4.b.(1) through (4) and (6).

(6) Depreciation, interest and real estate and personal property taxes
(a) Location of equipment when determinable.
(b) Same as C.4.b.(3)(b) square feet.
(c) Same as C.4.b.(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 C.4.b.(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.

D. REASONABLE COST PRINCIPLES

1. 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.

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 B.1.a.

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 D.3.a., and depreciation basis limitation D.4.b. 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 D.1. apply to all reported costs and have been specifically defined for certain cost elements in D.2. through D.8.

2. 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 D.8.d.(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.

3. 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

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

b. Assistant Administrator. Reasonable compensation of assistant administrators is not subject to the limitation in D.3.a.

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 D.3.a.

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 D.1.c. and D.3.a.

(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 D.8.d.(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) Pension and profit-sharing plans. Contributions to either an Internal Revenue Service approved pension or profit-sharing plan, but not both, are allowable costs.

(8) 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, C.3.b. unless not identifiable.

(9) Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.

(10) 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.

(11) Noncompetitive agreement. Costs of these agreements are not allowable.

(12) 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.

(13) Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.

(14) 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 D.6.a.

(15) Charitable contributions. These are not allowable costs.

(16) As provided in Minn. Stat. §256B.47, Subd. 2, the following shall not be recognized as allowable costs:

(a) Political contributions.

(b) Salaries or expenses of a lobbyist as defined in M.S.10A.01, Subd. 11, for lobbying activities.

(c) Advertising designed to encourage potential residents to select a particular home.

(d) Assessments levied by the Health Department for uncorrected violations.

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

(f) Dues paid to a nursing home or hospital association.

4. 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 D.4.a.(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:

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

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

(b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of D.4.a.(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 D.4.a.(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 D.4.a.(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 D.4.a.(2)(a)(ii) 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 D.4. 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:

(i) 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).

(ii) The gross recapture amount as determined in (i) 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.

(iii) The total net recapture amount determined according to (ii) 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 D.4.a.(2).

(b) The net recapture amount so determined in (iii) 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. 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 $13,000 per bed for licensed beds in two or more beds per room and $19,500 per bed for licensed private rooms built or purchased after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975 according to a construction index as determined by the Commissioner. The depreciable basis for licensed beds built or purchased prior to January 1, 1974 shall not exceed an average of $11,000 per bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private room which satisfy the certificate of need provision of B.3.c. 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.

(2) In no instance can accumulated depreciation calculated in accordance with D.4. exceed the basis defined in Section D.4.a.

(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 D.4.c. and D.4.d.

(4) Regardless of the applicability of the limitation stated in D.4.b.(1) above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under Section D.4.a. applying one of the "useful life" schedules defined in Section D.4.c.(1) or D.4.c.(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 D.4.c.(1) or D.4.c.(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 D.6.a.(1).) exceed the total depreciation allowance calculated in accordance with Section D.4. 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 D.4.a. Depreciation on any new construction or expansion of facilities commenced on or after January 1, 1977, other than governmentally owned facilities, shall be on a basis of not less than 30 years. For facilities constructed or expanded prior to January 1, 1977, and for facilities purchased after January 1, 1977, presently existing depreciation rules will apply.

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. Nursing-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 D.4.a.(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.

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	15
Gravel	5
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	15
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

5. 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 D.5.a.(1) or (2) exists, the provisions of D.5.b; 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. Limitation. Allowable rental charges are subject to the investment per bed limitations of D.6.b.(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 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.

6. Cost of Capital

a. Interest

(1) Except as provided in Section D.6.a.(6) interest is an allowable cost for non-proprietary facilities only and will be classified as follows:

(a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchase fixed assets related to providing nursing care as defined in D.6.b.(1) The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

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

(2) Interest income will be a deduction from interest allowable under provision D.6.a.(1)(a) or D.6.a.(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) After the first three years that a non-proprietary or governmentally owned nursing home has been owned by its current owners, the state agency shall not recognize as an allowable cost the expense of interest on net debt for any indebtedness and loans which exceed 100 percent of the net asset value of the facility.

(6) A proprietary nursing home which pays interest on capital indebtedness at an interest rate in excess of nine percent may be reimbursed for one-half of its interest expenses in excess of the nine percent up to 12 percent if (a) the proceeds of the indebtedness are used for the purchase or operation of the nursing home and (b) the interest rate is not in excess of what a borrower would have had to pay in an arms-length transaction at the time the loan was made.

b. Investment allowance.

(1). Determination of allowance. Proprietary homes where cost reports are received after January 1, 1977, shall receive an investment allowance of nine per cent of the original value of the facility for depreciation purposes. Non-proprietary homes whose fiscal year begins after June 30, 1977, shall receive an investment allowance of two per cent of the original value.

(2) For purposes of this section the following terms shall have the meaning given to them.

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

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

7. Welfare

All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patientsexclusively 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.

8. 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 rate of III.C.3.b. 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 D.8.a 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 D.8.a. 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 D.8.d.(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) Skilled care facilities which have a patient population with an average length of stay of 180 days or less may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. The average length of stay is determined by dividing the actual patient days for the historical fiscal year by the total discharges for the historical fiscal year.

E. IMPLEMENTATION PROCEDURES

1. Effective Date of DPW Rule 49 Revisions

a. Unless noted otherwise, all changes are effective for rates set for cost reports received by the Department of Public Welfare after January 1, 1977. Changes in the cost-of-capital allowance for non-proprietary facilities other than non-proprietary lease facilities are effective July 1, 1977.

F. SEVERABLE PROVISIONS

1. If any provisions of the rule as adopted by Commissioner of Public Welfare are found to be unreasonable or not supported by the evidence, the remaining provisons shall remain valid.