

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 6/1 Temporary Rule —

Resubmitted and Received _____

DUE DATE 6/21

a. Returned to Agency w/o filing w/Secy of State _____
b. Approved _____ Date Sent Back to Agency _____

- -

1. Rules as Adopted ✓
2. Rules as Proposed ✓
3. Certificate of Board's Authorizing Resolution, where applicable N.A.
4. Order for Hearing ✓
5. Notice of Hearing ✓
   (i) Sufficiency ✓
6. Secretary of State's List ✓
7. Certificate of Acquisition of Secretary of State's List ✓
8. Affidavit of Mailing ✓
   (i) At least 30 days prior to hearing ✓
9. Statement of Need and Evidence ✓
10. Hearing Examiner's Report ✓
11. Agency's Findings of Fact ✓
12. Certificate of Board's Resolution Adopting Rules, where applicable _____
13. Order Adopting ✓
14. Report of Chief Hearing Examiner ✓
    (i) Finding of No Substantial Change ✓
    (ii) Permission to Incorporate by Reference, where applicable N.A.
15. Certificate of Compliance with Rulemaking Procedures ✓
16. Copy of Notice of Intent to Solicit Outside Opinion, where applicable N.A
17. Petition by Public, where applicable N.A.

Zerby read [redacted] order to me over [redacted] phone. 6-26-78

Q Does James ~~Hunter~~ Hiniker (?) have a delegation for Dirksage to adopt rules

? p. 5 (of proposal) No finding on "where applicable" repeal.

gratitious question p. 11 - proposal rules (16) (B) - no expenses as in former rule.

in existing rule p. 19 of Adopted rules (16) (c) - No finding of "cruciality"

in existing rule p. 25 of Adopted Rules - (b)(1) Quotes stat. lang. w/o finding of cruciality

Paul Zerby
Deputy Attorney General

June 27, 1978

- DPW 49, Determining Welfare Per Diem Rates for Nursing Home Providers

cc: Duane Harves

ADOPTED RULE

Exhibit C

RECEIVED
MAY 17 1978
OFFICE OF HEARING
EXAMINERS

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 August 1, 1977

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DPW 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 Aministrative 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 by 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 rates.

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, subtract 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 previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. 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 in the notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

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 forecast results.

(2) Report compliance. Reports will comply with all applicable sections of these regulations governing cost finding, reporting, and allowable costs to the extent feasible in the individual circumstances. Noncompliance with any provision of these regulations must be so stated together with the 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.(2) shall receive up to 85% of what their skilled rate would have been without application of B.4.c.(2).

(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 by federal and state 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 B.3.e. 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 D.8.d.(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 statement 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 will maintain statistical and accounting records to support information in no less detail than that required by C.1.a. required reports for at least three years following submission of a cost report. The provider shall also make available federal and state income tax returns upon request of Department personnel.

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 noncompliance 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 at least every three years will be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider 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)h. 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 classification).

(b) Cost allocation on the basis of regularly validated time or cost studies.

(c) Remaining costs (e.g. nursing supervisor, supplies, etc.) not classified under methods (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. The nursing care limitation under D.2.a. and the investment per bed limitation under D.4.b.(1) will be waived when the Medicare cost allocation factors result in these limitations being exceeded. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups:
(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, or facilities mandated by a correction order from the Department of Health to provide additional nursing care.

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.3.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) Other general and administrative costs. As provided in Minn. Stat. § 256B.47, Subd. 2, the following shall not be recognized as allowable costs unless otherwise noted:

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

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

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

(d) Assessments levied by the Health Department for uncorrected violations. Assessments levied and collected by the Minnesota Health Department shall not be recognized as allowable costs.

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

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

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

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 percent. 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 percent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the State of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of 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 deprecation 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. This limitation will not apply to governmentally owned nursing homes.

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.

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.4.b.(1) determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of 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. Effective July 1, 1977, interest expense on indebtedness incurred prior to April 13, 1976, is exempted from this provision if the expense is allowable according to Section D.6.a.(1).

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

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 percent 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 percent of the original value. For each year after the year in which the nursing home was originally purchased in which there is no transfer of ownership of a nursing home, the investment allowance shall be increased by one percent of the original investment allowance, but the increases shall be limited to a maximum of 25 percent of the original investment allowance effective for rates paid on August 1, 1977.

(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 depreciated replacement cost basis. If a nursing home expands its facility or makes any other capital expenditure which increases the value of the facility, the cost of the expansion or capital expenditure shall be added to the original value. If the Department disputes the cost of the expansion or capital expenditure, it may request an appraisal and use the appraised value as the allowed cost.

(3) Allowance for leased facilities. Leased facilities shall receive an investment allowance not to exceed the greater of $.35 per the facility's 93% capacity patient days or the investment allowance of Section D.6.b.(1) for those fixed assets owned by the lessee facility.

7. Welfare

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

8. Facility Utilization Incentives

a. Capacity limitation. The allowable cost amount per patient day depreciation, interest, property taxes, administration and earnings allowance will be calculated by dividing such allowable costs by 93 percent of total capacity patient days for licensed beds. Facilities qualifying for the special care rate of III.C.3.b. may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 percent of total capacity patient days for licensed beds.

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

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 percent welfare patient days may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. "Extreme hardship" will include a financial situation in which projected cash flow indicates the fact that debt and operating obligations cannot be met.

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

E. IMPLEMENTATION PROCEDURES

1. Effective Date of DPW Rule 49 Revisions

a. Unless noted otherwise, all changes are effective for rates paid August 1, 1977 and subsequent.

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 provisions shall remain valid.

APPROVED AS TO FORM AND LEGALITY

June 26 1978

WARREN SPANNAUS, ATTORNEY GENERAL

BY Lee E. Shelby

SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JUN 26 1978
Joan Anderson Growe
Secretary of State

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JUN 26 1978
Joan Anderson Growe
Secretary of State

3:40 pm

Rules as Proposed

DPW 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 Minn. Stat. § 256b.27 to require reports, information and audits, and pursuant to Minn. Stat. § 256B.14, subd. 2, to promulgate rules and regulations for carrying out and enforcing the provisions of Minn. Stat. ch. 256B. This regulation is further promulgated pursuant to the procedures set our in Minn. Stat. § 15.0412, of the Minnesota Administrative Procedures Act.

2. Objectives. The procedures embodied herein define a system for the determination of a per-diem welfare rate for all nursing homes participating in the Medical Assistance Program 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 percent or more of the facility population.

Procedures have been defined to satisfy the State Plan for Medical Assistance and HEW Medical Services Administration Program Regulation Guide 19, which 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 (Minn. Stat. § 256B.04, subd. 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 by 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 lease.

(i) Raw food cost increase comr
by multiplying $1.20 times one-half the perc

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, subtract 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 1976 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.e.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 previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. 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 in the notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

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 forecast results.

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

(3) Interim rate establishment. The Commissioner will establish an interim rate in accordance with regu-

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lations 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 in 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.(2) shall receive up to 85% of what their skilled rate would have been without application of B.4.c.(2).

(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 IIfor 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 and state 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 B.3.e. Regions will be those areas designated by the Governor for regional planning and economic-development purposes. Regions may be combined when deemed appropriate by the Commissioner as announced through policy bulletins. The regional averages will be calculated separately for proprietary, nonproprietary and hospital-attached facilities except the regional average costs for hospital-attached facilities shall be included in the regional average calculation for nonproprietary free-standing facilities. The maximum-rate limitations will be adjusted annually through policy bulletins. The regional averages will be determined by the Commissioner, using all available information from reports that indicate a fiscal-year end during a calendar year and will be applied to rates that become effective during the second succeeding calendar year. Facilities that have a noncalendar-year end and have been previously subject to the maximum rates may adjust the rates to the new maximum rates if previously justified by the reports.]

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.e. 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 to indirect costs. All other cost items are included in the direct care maximum calculations.

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 which have a non-calendar year-end and 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. This provision of the rule is effective for rates paid on the first day of the month following adoption of the provision.

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 increase 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 D.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 per cent for the first two immediate fiscal years.

(4) A welfare per-diem rate component in excess of either of the maximum rate limitations contained in B.4.b. will be allowed to the extent of 85 percent 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 percent of total capacity patient days, whichever is greater provided that in no event shall this section affect a per-diem rate by more than $1.70.

(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 percent of the regional average as defined in B.4.b.

5. Appeals 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. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate when

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determined according to desk audit and rate notification of section B.2.b., the new per-diem rate with retroactive adjustment for the prior issuance of a temporary rate of section B.2.b. or the interim rate of section C.1.c. will be effected prior to final determination according to these appeal procedures. If the dispute is related to a change in the provider's rate(s) as the result of field audit according to sections B.2.c. and C.1.g. or as the result of a lack of implementation of known cost changes according to section B.1.c.(2)., the total dollar amount due the program or the provider resulting from the resolution of the appeal will be subject to the payment provision of section 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 of ten percent or more of the facility.

(8) Required reports will include audited balance sheet and statement of revenues and expenses. This provision of the rule is effective for the cost reporting period ending on the last day of the month during which this provision of the rule is adopted.

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 **for at least three years following submission of a cost report.** The provider shall also make available federal and state income tax returns upon request of Department personnel.

d. Report certification.

(1) Reports required in regulation C.1.a. will be accompanied by a certification of (a) the majority owner defined as the person having over 50 percent effective ownership, or the chief financial officer if there is no majority owner, and (b) 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 re

ject 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 percent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the Commissioner.

(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 **at least every three years will** [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 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. Cost 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 outsider, the cost to the provider shall be the outsider's price; however, sales to outsiders must constitute at least 2[illegible] 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

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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, supervision 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 pharamcy, 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	Cerification	
	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.

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(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 and 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. The nursing care limitation under D.2.a. and the investment per bed limitation under D.4.b.(1) will be waived when the Medicare cost allocation factors result in these limitations being exceeded. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups:

(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 ordinarly 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, **or facilities mandated by a correction order from the Department of Health to provide additional nursing care.**

b. Attendants (ICF II facilities only). Reasonable costs for attendants in ICF II faciliites 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 ration 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 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 effective 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.3.1.

(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. Cost incurred in connection with membership in all organizations not included in D.8d.(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

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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 purposes 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) Other general and administrative costs. As provided in Minn. Stat. § 256B.47, subd. 2, the following shall not be recognized as allowable costs **unless otherwise noted**:

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

[(b) Salaries or expenses of a lobbyist as defined in Minn. Stat. § 10A.01, subd. 11, for lobbying activities.]

(B) Salary of a lobbyist. The salary of an individual in the employ of a facility shall be allowed for lobbying activities as defined in Sec. 10A.01, Subd. 11 only if the lobbying activity is incidental to the individual's job functions and if such lobbying directly relates to the licensed functions of the facility.]

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

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

(d) Assessments levied by the Health Department for uncorrected violations. **Assessments levied and collected by the Minnesota Health Department shall not be recognized as allowable costs.**

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

(e) Legal fees. Fees incurred in unsuccessful legal challenges where a government agency is a party to the suit are not directly related to patient care and will not be allowed. A legal action is unsuccessful to the extent that the nursing home does not demonstrate it clearly prevailed on the issues litigated. Legal challenges include, but are not limited to, appeals regarding rates, licensure, and certification at all levels as well as direct court challenges.

[(f) Due paid to a nursing home or hospital association.]

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

Each association for which dues are claimed as an allowable cost must file annually with the department a statement summarizing its activities, its revenues generated by dues and its expenditures of funds received from dues payments. The percentage (up to 100%) of dues revenue which the association expends for direct care purposes as defined above will be allowed during the next year. The statement must be filed within 30 days of the end of the association's fiscal year except that in order for dues to be allowable effective September 1, 1977 each association must file such a statement by October 1, 1977 covering its most recently completed fiscal year. No expenditures by an association which would be unallowable for rate setting purposes will be considered

directly related to patient care. This provision of the rule is effective for rates paid on September 1, 1977.

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

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can be included 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.(a) 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.

(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. **This limitation will not apply to governmentally owned nursing homes.**

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.

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 × 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)(a). The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

(b) Other interest for working capital and operating needs that directly relate to providing nursing care is an allowable cost. The form of indebtedness will include, but is 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. **Effective July 1, 1977, interest expense on indebtedness incurred prior to April 13, 1976, is exempted from this provision if the expense is allowable according to section D.6.a.(1).**

[(6) A proprietary nursing home which pays

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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 exces sof what a borrower would have had to pay in an arms-length transaction at the time the loan was made.]

(6) Interest expense for a proprietary nursing home will be allowable on capital indebtedness which has a rate of interest in excess of nine percent, but no more than twelve percent, if the indebtedness relates directly to the purchase of the facility or to working capital for the operation of the facility and if the rate of interest does not exceed a rate which a prudent and cost-conscious borrower would incur in an arms-length transaction.

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 percent 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 percent of the original value.]

Proprietary homes where cost reports are received after January 1, 1977 shall receive an investment allowance of nine percent of the original value of the facility for depreciation purposes of section D.4.b.(1) plus one percent of the nine percent for each year of ownership not to exceed 11.25 percent of the original facility value. Non-proprietary homes shall receive effective July 1, 1977 an investment allowance of two percent of the original facility value plus one percent of the two percent for each year of ownership not to exceed 2.5 percent of the original facility value. Where additional beds are added to an existing bed complement according to section D.4.a.(2)(b), a separate computation for the ownership incentive will be required either for the additional beds with ownership years accruing from the date of licensure of those new beds or for the additional investment in fixed assets with ownership years accruing from the date of the change in ownership. The ownership incentive is effective for rates paid on August 1, 1977.

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

(a) Facility means the nursing home building and all permanent fixtures attached to it. **Fixtures mean property which is actually attached to the building so as to constitute a part thereof.** Facility does not include the land or any supplies and equipment which are not fixtures.

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

(3) Allowance for leased facilities. Leased facilities shall receive an investment allowance not to exceed the greater of $.35 per the facility's 93% capacity patient days or the investment allowance of section D.6.b.(1) for those fixed assets owned by the lessee facility.

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

8. Facility utilization incentives.

[a. Capacity limitation. The allowable cost amount per patient day depreciation, interest, property taxes, administration and earnings allowance will be calculated by dividing such allowable costs by 93 percent of total capacity patient days for licensed beds. Facilities qualifying for the special care rate of III.C.3.b. may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 percent of total capacity patient days for licensed beds.]

a. Capacity limitation. The allowable cost amount per patient day for depreciation, interest, property taxes, administration and investment allowance will be calculated by dividing such allowable costs by 93 percent of total capacity patient days for licensed beds or actual patient days, whichever is greater. Facilities qualifying for the special care rate of C.3.c.(2) may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 percent of total capacity days for licensed beds. This provision of the rule is effective for rates paid on the first day of the month following adoption of the provision.

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 annual average length of stay of 180 days or less may be granted an annual waiver by the Commissioner of this capacity calculation and be allowed a rate based on actual patient days. The average length of stay is determined by dividing the actual patient days for the historical fiscal year by the total discharges for the historical fiscal year.]

(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 total discharge patient days for all years by the total discharges for the historical fiscal year. This provision of the rule is effective for the cost reporting period ending on the last day of the month during which this provision of the rule is adopted.

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.]

a. Unless noted otherwise, all changes are effective for rates paid August 1, 1977 and subsequent.

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 provisions shall remain valid.

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STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE EDWARD J. DIRKSWAGER, JR.

COMMISSIONER OF PUBLIC WELFARE

RECEIVED
MAY 17 1978
OFFICE OF HEARING EXAMINERS

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

ORDER ADOPTING RULES

The above-mentioned matter came on for hearing before Mr. Robert W. Herr, Hearing Examiner appointed by the Chief Hearing Examiner on October 21, and 25, 1977 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; Paul Zerby, Assistant Attorney General; and Robert Rau, Audit Director. Approximately one-hundred (100) 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 18, 1978, a copy of which is attached as Exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minnesota Statutes, Section 15.0412, Subdivision 4 (1976) said Report was available to all affected persons for over ten (10) days subsequent to the date of the Report.

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 Report of the Hearing Examiner, and upon all of 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 Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner dated January 18, 1978 to the following extent:

1. Findings of Fact of the Hearing Examiner 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 21, 22, 23, 24, 25, 26, 27, 29, 32, 33, 34, 35, 36, 39, 40, 43, 44, 47 49 and 51 are adopted and incorporated in full.

2. Findings of Fact 14 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

   The Department testified at length (T-12-16, 75-79) concerning the original application of the 125 percent overall rate limitation and the proposed 125 percent direct and indirect rate limitation. The 125 percent factor was promulgated and established in the July 1, 1973 version of the rule. Since it was not the intent of the legislature to repeal or change any existing rule promulgated by the state agency relating to the setting of rates for nursing homes unless it was clearly in conflict with the act, it is reasonable to utilize the existing 125 percent factor. Considerable testimony and written comments were received in opposition to the application of the 125 percent factor for indirect costs, especially in regard to government-owned homes and newly-constructed facilities. Therefore, the Department will withdraw the provision.

3. Findings of Fact 15 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-15) concerning the division of costs between direct and indirect categories. Under the current methodology developed as of November 1, 1972 (effective date of the original Rule 49) variable costs have been divided by actual patient days and therefore are now appropriately deemed direct costs. Fixed costs have been divided by the 93% capacity days and therefore are now appropriately deemed indirect costs. Property-related costs and the investment or capital allowance have consistently been identified as fixed costs and therefore they are appropriately and reasonably classified with the indirect costs. The Department further testified (T-78) that the investment allowance (earnings or cost of capital allowance) has historically been identified as a cost under the reasonable cost principles of the rule, it has been an allowable cost historically governed by the maximum rate limitation, and therefore without specific legislation exempting such cost from the indirect maximum rate it is reasonable for such cost to be included in the indirect maximum rate. However, based on the previous finding, this finding is moot and the Department will withdraw the provision.

4. Findings of Fact 18 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified at length (T-16-19 and 84-89) concerning the types of welfare rate determinations in order to clarify the current administration of the rule. The Department indicated that 1 percent of the cases or less (T-86) resulted in the temporary rate being in excess of the final rate. There was also testimony (T-33-34-Vol. II) to the fact that temporary rates are issued without audit and it would be reasonable to collect the overpayment of such temporary rates when the final rates are established. The Department indicated that there had been no appeals of the adjustment of an interim rate to a settle-up rate. The proposed amendment is reasonable and is authorized by Minn. Stat. § 256B.04, Subd. 2 for the efficient administration of the Medical Assistance Program funds. However, due to the volume of adverse testimony on this provision, the Department will withdraw the proposal.

5. Findings of Fact 19 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-19-20 and 89-90) concerning the need for audited statements of revenue and expenses as required by Minn. Stat. 256B.48, Subd.2. As a condition of participation in the Medical Assistance Program providers must agree in writing to supplement their annual cost reports which they submit to the Department for welfare rate determination with the audited statements. The criteria of the proposed provision is reasonable in conjunction with the statute. However, due to the volume of adverse testimony on this provision, the Department will withdraw the proposal.

6. Findings of Fact 20 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-20) that this rule provision would be effective for those cost reporting periods which would end on the last day of the month in which this provision of the rule was adopted. Based on the example cited at the hearing to illustrate the implementation date, the proposed amendment is clear and is reasonable and necessary. However, based on the previous finding, this finding is moot and the Department will withdraw the provision.

7. Findings of Fact 28 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-30-33 and 104-106) concerning the cost allowability of association dues. The Department cited examples (T-32 and 106) of association costs that would not be allowable because such costs are not allowable directly to the nursing homes which the association represents. The criteria of the proposed provision is reasonable and necessary. However, due to the volume of adverse testimony on this provision, the last sentence of the proposed provision shall be deleted.

8. Findings of Fact 30 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified at length (T-29-30 and 97-104) concerning criteria for measuring the allowability of legal fees. Testimony at the hearing from interested parties indicated that the criteria necessary for this provision would require an enormous part of the rule. Therefore the proposed criteria will be deleted and the statutory language shall prevail.

9. Findings of Fact 31 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

In the proposed criteria for measuring the allowability of legal fees the Department stated (T-29) that fees incurred in unsuccessful legal challenges where a governmental agency is a party to the suit are not directly related to patient care and will not be allowed. This proposal is a reasonable conclusion from Minn. Stat. § 256B.47, Subd. 2. However, the finding is moot based on the previous finding that the proposed criteria will be deleted.

10. Findings of Fact 37 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-39-40 and 117-120) concerning the application of increased investment allowance for the investment in additional beds. The Department cited an example (T-118) of the unintended financial benefit which would occur if providers were allowed to claim the investment on additional beds retroactive to the date of original acquisition or purchase of the facility. The criteria of the proposed provision is reasonable. However, due to the volume of adverse testimony on this provision, the Department will delete the provision and utilize the statute language.

11. Findings of Fact 38 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-85-87-Vol.II) concerning the application of the original value of the facility as used in the determination of allowable depreciation expense.

This criteria of the proposed provision is reasonable. However, based on the previous finding, the Department will delete the provision and utilize the statute language.

12. Findings of Fact 41 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-41 and 121-125) concerning a definition for the word "fixture". The Department sought to define "fixture" in order to establish the fact that supplies and equipment which are not fixtures are not included in the investment allowance (Minn. Stat. § 256B.42, Subd.2). The criteria of the proposed provision is reasonable. However, due to the volume of adverse testimony on this provision, the Department will withdraw the provision and will seek statutory language clarification.

13. Findings of Fact 42 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department's testimony (T-41 and 121-125) did relate to the legal authority of the proposal and to its reasonableness to the extent that the proposal could be interpreted from the definition of facility. However, based on the previous finding, this finding is moot and the Department will withdraw the provision.

14. Findings of Fact 45 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-42-45 and 128-133) that the 93% capacity provision of the rule was a mechanism for extra reimbursement for those facilities maintaining occupancy in excess of 93% of licensed capacity. The Department also testified that the Select Subcommittee had reviewed the proposed deletion of the incentive provision in compliance with Minn. Stat. § 256B.45, Subd.1. and agreed that the Department had correctly interpreted that provision of the law. The criteria of the proposed provision is reasonable. However, due to the volume of adverse testimony on this provision, the Department will withdraw the proposal.

15. Findings of Fact 46 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-132-133) concerning the equity of deleting the Facility Utilization Incentives - Capacity Limitation from the rate determinations of both proprietary and non-proprietary facilities. However, based on the previous finding, this finding is moot and the Department will withdraw the proposal.

16. Findings of Fact 48 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department testified (T-45-48 and 134-136) concerning a proposed change to the methodology for computing an average length of stay for waiver of the capacity limitation provision. The Department further testified (T-46) that the proposal was the result of two appeal hearings and the result of the Minnesota Department of Health changing its methodology for computing such an average length of stay. The criteria of the proposed criteria is reasonable based on such testimony.

17. Findings of Fact 50 of the Hearing Examiner is rejected and the following finding is adopted in lieu thereof:

The Department in its testimony did not explicitly demonstrate the effect which the change in terminology and/or methodology would have upon the currently-affected providers and did not elaborate on the definition of the term "discharge". These factors do not detract from the reasonableness of the proposed amendment. However, due to the volume of adverse testimony on this provision, the Department will withdraw the proposal.

18. Conclusions 1, 2 and 3 of the Hearing Examiner are adopted and incorporated in full.

19. Conclusion 4 of the Hearing Examiner is rejected and the following conclusion is adopted in lieu thereof:

The Department will delete and/or withdraw all or part of the following proposed provisions as indicated in certain Findings of Fact:

Maximum Rate Limitation - SectionB.4.b.
Effective Date of Resolved Disputes - Section B.5.c.
Audited Statements - Section C.1.a.(8)
Legal Fees - Section D.3.d.(16)(e)
Incentive Allowance for Continuous Ownership - Section D.6.b.(1)
Definition of Facility - Section D.6.b.(2)(a)
Capacity Limitation - Section D.8.a.
Average Length of Stay - Section D.8.d.(3)

20. Recommendation 1 of the Hearing Examiner is rejected and the Department's aforementioned Conclusion 4 is adopted in lieu thereof.

21. Recommendation 2 of the Hearing Examiner is adopted and incorporated in full.

IT IS FURTHER ORDERED that the Commissioner hereby adopts the proposed amendment to Rule 49 of the Minnesota Department of Public Welfare so that from and after this day of March 29, 1978, 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.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

EDWARD J. DIRKSWAGER, JR.
COMMISSIONER

DPW-7[illegible]021-RH "Exhibit 6"

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MAY 17 1978
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the Department of Public Welfare Governing the Determination of Welfare Per-diem Rates for Nursing Home Providers, Under Title XIX Medical Assistance Program, Rule 49.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing before Hearing Examiner Robert W. Herr of the Minnesota Office of Hearing Examiners at 8:30 o'clock a.m., October 21, 1977, at the State Office Building Auditorium, St. Paul, Minneosta, pursuant to an Order for Hearing issued on September 9, 1977, by Edward J. Dirkswager, Jr., Acting Commissioner of the Minnesota Department of Public Welfare (hereinafter "the Department"). The Hearing recessed at the end of that day and resumed at 12:30 o'clock p.m., on October 25, 1977, at Room 14 of the State Office Building.

Paul Zerby, Assistant Attorney General, represented the Department at the hearing. The Department panel consisted of Robert J. Rau, Director of the Department's Audit Division, and James Hiniker, Deputy Commissioner of the Department.

Approximately 100 persons attended the hearing. Of this number 16 presented testimony and/or written statements at the hearing. Members of the Department Panel were questioned by several of the persons testifying at the hearing.

The hearing continued until all interested persons had an opportunity to be heard concerning the adoption of the proposed rules.

The Hearing Examiner received 28 written comments, statements or other submittals following the conclusion of the

hearing. All such documents were reviewed and considered by the Hearing Examiner and are included in the record of the hearing in this matter.

Pursuant to Minn. Stat § 15.0412, Subd. 4, (1977), this Report shall be available for review to all affected individuals upon request for at least five days. The Department shall, if it proposes to adopt the proposals as originally submitted or as amended at the hearing, submit the complete hearing record, including its Findings and Order to the Chief Hearing Examiner no earlier than five days subsequent to the receipt of this Report. This submission shall clearly indicate any changes made to the proposals which were originally proposed, preferably in the format that will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Department on the issues of substantial changes in the Rule in compliance with Minn. Stat. § 15.0412 (1977) within ten calendar days. Thereafter the Department shall be responsible for filing the Rules with the Attorney General and for notifying persons who have indicated that they wish to be notified of such filing.

Based upon all of the records and proceedings herein, the Hearing Examiner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. On September 19, 1977, a copy of the Notice of Hearing and a copy of the Proposed Rule were published at 2 State Register 617.

2. On September 19, 1977, the Department filed the following documents with the Chief Hearing Examiner:

(a) A copy of the Proposed Rules;
(b) A Proposed Order for Hearing;
(c) A Proposed Notice of Hearing.

The Department did not file a statement of the number of persons

expected to attend the hearing and the estimated length of time that will be necessary to conduct the hearing as required by H E 102 (d).

3. On September 16, 1977, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On September 22, 1977, the Department filed the following documents with the Chief Hearing Examiner:

(a) Notice of Hearing as mailed;
(b) Certificate of Delivery of Secretary of State's list and Affidavit of Receipt of Secretary of State's list;
(c) Affidavit of Mailing of Notice of Hearing;
(d) Statement of Need;
(e) Statement of Evidence.

The Department did not file an Order for Hearing as required by H E 103. The foregoing documents, with the exception of the Order for Hearing, were available for inspection at the Office of Hearing Examiners from the date of filing to the date of hearing.

5. The Hearing Examiner notified all persons present at the hearing that the record would remain open through November 14, 1977, for the receipt of written statements or materials.

6. The Rules of the Department of Public Welfare Governing the Determination of Welfare Per-Diem Rates for Nursing Home Providers Under Title XIX Medical Assistance Program (hereinafter "Rule 49") were the subject of a prior public hearing held November 12-13, 1976, resulting in certain modifications to Rule 49 being made effective August 15, 1977. In addition, a temporary emergency measure authorized by Minn. Stat. § 256B.47, Subd. 2, governing certain general and administrative costs which would be recognized as allowable costs

became effective September 1, 1977, to remain effective for 90 days unless reissued or continued in effect by the Department for an additional 90 days. At the hearing in the instant matter the Department proposed that the adopted temporary rule, with certain modifications, be adopted as Section D 3 D d (16) of Rule 49.

Statutory Authority

7. The basic grant of rule-making authority to the Department is contained in Minn. Stat. § 256B.04, Subd. 2, which requires the Department to adopt rules for carrying out and enforcing the provisions of the Medical Assistance Program. Other specific provisions of law direct the Department to require reports and make rules for various specific purposes. Such rule making authority will be referenced throughout this Report.

Proposed Amendment to Rule 49 B 4 a -- Rate Limitations

8. Existing Rule 49 B 4 a deals with rate limitations. The proposed amendment adds the words "and state" to a portion of the existing rule so that it will read in part: "Welfare rates may further be limited to federal and state laws or regulations that affect the Medical Assistance Program." Mr. Rau testified that the proposed change is made for the purpose of recognizing that several provisions of state law and regulations currently limit such rates. The existing rule is, therefore, made more accurate and complete by the addition of such language, according to Rau.

9. One witness argued that the added language was unnecessary. The Hearing Examiner agrees but believes that the added words will render the rule a more accurate and complete statement of existing rate limitations.

10. One witness suggested that the word "to" preceding "federal and state" should be changed to "by". The Hearing

Examiner agrees that such change would be a grammatical improvement and is of the view that such change would not be a substantive change.

Proposed Amendment to Rule 49 B 4 b -- Rate Limitations-Maximum Rate

11. The proposed amendment establishes an overall limitation on the allowable cost for items which directly relate to the provision of patient care to residents of nursing homes and for items which do not directly relate to the provision of such care. The limitations proposed are 125 percent of regional average costs, the current methodology. What is new about the proposal is the ceiling upon indirect costs and the delineation of the same: costs of depreciation; real estate taxes; investment or capital allowance; interest; rent; and those costs reported as general administration on Rule 49 Cost Reports.

12. The justification for the Department's proposal to establish a limitation on the cost of items which do not directly relate to the provision of care is found in Minn. Stat. § 256B.47, Subd. 1:

> The state agency shall by rule establish separate overall limitations on the costs 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 state agency may also by rule establish limitations for specific cost categories....

13. The Department's justification for setting the ceiling on indirect costs at 125 percent is Minn. Stat. § 256B.41, Subd. 2, which states that it was not the intent of the legislature to change any existing rule of the Department relating to the setting of rates for nursing homes. Rau indicated that the 125 percent limitation with respect to direct costs was in existence at the time of enactment of Minn. Stat. § 256B. 41, Subd. 2.

14. The Hearing Examiner, however, does not agree that the Department is confined to the 125 percent limitation. The Department offered no evidence indicating that the 125 percent limitation on indirect costs is either reasonable or necessary. In this connection it is noted that the testimony and written statements of virtually all witnesses and interested persons opposed the 125 percent limitation, both in principal and in amount. Of particular significance were the comments and written statements indicating that government owned facilities would be drastically affected by the 125 percent limitation on indirect costs because such facilities incur indirect costs, such as public employees' retirement contributions, which other facilities do not incur and that newly constructed facilities, whose fixed costs were high due to construction at inflated prices, would be drastically affected.

15. The Department likewise failed to present any substantial evidence or argument that property related costs should be subject to the same limitation as other so-called indirect costs or that the investment or capital allowance is an indirect cost or that it should be limited as proposed.

16. The proposal to amend Rule 49 B 4 b would also make the provision effective for rates paid on the first day of the month following the adoption of the provision. There was no comment regarding this change. The Hearing Examiner is of the view that this provision is reasonable and necessary to inform providers of the effect of the rate limitation proposed elsewhere in this amendment should the proposed amendment become effective.

Proposed Amendment to Rule 49 B 5 c -- Appeals Procedures - Effective Date of Resolved Disputes

17. A typographical error in the first sentence of the proposed change caused the word "change" to be "charge".

This typographical error should be corrected if the proposal is adopted.

18. The existing rule provides that in the event a provider disputes an adjustment by the Department of its rates resulting from an audit by the Department, the new rate will prevail until a final determination following appeal is made; and in the event the adjustment results in a payment from the provider to the Department following final resolution of the dispute, the provider has 120 days from the date of notification of the adjustment to make such payment. The proposed amendment would continue this arrangement with respect to rates other than temporary or interim rates. For such rates the proposal would require recoupment of any alleged overpayments prior to the final resolution by appeal. Mr. Rau testified that this proposal reflects the existing practice of the Department but that in no more than one percent of the cases involving interim or temporary rate adjustments is the final rate less than the temporary or interim rate originally permitted. Rau did not indicate the amount of money involved in such cases or whether such recoupment was successfully or unsuccessfully challenged by the provider(s) involved. Lacking such evidence, the Hearing Examiner is of the view that the Department presented no justification for such a drastic modification of the existing rule. The Department cited no statutory authority for the proposal. The Hearing Examiner is of the view that the proposed amendment is not authorized or required by law and that it may run afoul of due process protections to which providers may be entitled..

Proposed Amendment to Rule 49 C 1 a (8) -- Reports

19. The existing rule identifies the documentation or information required to be filed with the Department by providers for welfare rate determination. The proposed

amendment adds the requirement that an audited balance sheet and statement of revenue and expenses be furnished to the Department by providers with their annual cost reports in connection with welfare rate determinations. The Department cites Minn. Stat. § 256B.48 , Subd. 2, as the basis for such proposal. That provision, however, requires only that a nursing home "agree in writing" to provide the Department with "its most recent... balance sheet and statement of revenues and expenses as audited by a certified public accountant...." Since the statute does not require providers to prepare or furnish annual audited financial statements, the Department can not require such by rule. Further, since the Department regularly audits providers, either in the field or at its offices, imposition of the proposed requirement is unreasonable and unnecessary.

20. The meaning of the balance of the proposed amendment relating to the effective date of the new requirement is unclear. Because of this and because the foregoing Finding of Fact relating to the proposal, no finding regarding the need or reasonableness of the proposal with respect to the effective date is made.

Proposed Amendment to Rule 49 C 1 c -- Records

21. By this proposal the Department imposes a requirement upon providers that statistical and accounting records and supporting information currently required to be furnished to the Department by providers be maintained by providers "for at least three years following submission of a cost report." The authority for such requirement is Minn. Stat. § 256B.27, Subd. 2a, which specifies that the Department audit cost reports of providers at least once every three years. There was no opposition to this proposal, and the proposal appears reasonable and necessary to accomplish the purpose of complying

with the requirement of Minn. Stat. 256B.27, Sibd. 2a.

Proposed Amendment to Rule 49 C 1 g -- Audits

22. By this proposed amendment the Department informs providers that cost reports will be subject to field examination of supporting records and compliance with regulations "at least every three years." This proposal simply tracts Minn. Stat. § 256B.27, Subd. 2a, which provides for a departmental audit of cost reports at least every three years. This proposal is necessary to bring the existing rule into compliance with Minn. Stat. § 256B.27, Subd. 2a.

Proposed Amendment to Rule 49 D 2 a -- Reasonable cost principals - Nursing Care and Attendant Limitations

23. The proposed amendment recognizes an exception to the limitation embodied in the existing rule with respect to the number of nursing hours for which a provider may seek reimbursement. The exception contained in the proposed amendment follows the mandate of Minn. Stat. § 256B.47, Subd. 1, to the Department to allow the cost of nursing care in excess of the existing limits on hours of nursing care if the Board of Health issues a correction order directing the provider to provide the additional nursing care. Although the proposed rule thus parallels the statute, its inclusion in Rule 49 as proposed is reasonable and necessary to make the existing rule, which contains other nursing hour reimbursement exceptions, fully informative to providers.

24. Much discussion and comment was presented regarding the method the Department would use to implement the proposed amendment. The Hearing Examiner is of the view that the methodology to be utilized by the Department is beyond the scope of the hearing in this matter, and the above finding regarding this proposal is made without regard to the Department's announced methodology for implementation of the proposal.

Proposed Amendment to Rule 49 D 3 d (16) (a) - (f) -- Reasonable Cost Principles - General and Administrative Expenses

25. The proposed amendment is based upon Minn. Stat. § 256B.47, Subd. 2, which provides as follows:

> "The following costs shall not be recognized as allowable to the extent that these costs can not be demonstrated by the nursing home to the state agency to be directly related to the provision care:
>
> (1) Political contributions;
> (2) Salaries or expenses of a lobbyist, as defined in Section 10 A.01, Subd. 11, for lobbying activities;
> (3) Advertising designed to encourage potential residents to select a particular nursing home;
> (4) Assessments levied by the Health Department for uncorrected violations;
> (5) Legal fees for unsuccessful challenges to decisions by state agencies; and
> (6) Dues paid to a nursing home or hospital association.
>
> The state agency shall promulgate rules establishing standards which shall distinguish between any patient-care related components and nonpatient-care related components of these costs, where applicable....

This provision also authorizes the Department to promulgate emergency rules, and, as noted earlier in this Report, the Department has done so. Prior to 1977, Minn. Stat. § 256B.47, Subd. 2, specified that none of the above listed items were to be recognized as allowable by the Department.

26. What the Department has apparently done in connection with proposals (a) and (d) is to construe the amended statute to prohibit entirely the recognition of political contributions and assessments levied by the Health Department for uncorrected violations. The Department submitted no evidence with respect to the reasonableness of its proposals relating to such items. The Hearing Examiner is of the view, however, that such total prohibition is justified in that such items do not appear to require creation of standards; and in any event, any attempt to create standards with respect to such

items would be virtually impossible if not wholly unwise. There was no opposition to the proposals with respect to these items. The Hearing Examiner is of the view that proposals 16 (a) and (d) are reasonable and necessary.

27. With respect to proposals 16 (b), (c) and (f) it appears that the Department has attempted to establish standards which distinguish between "patient-care related components and nonpatient-care related components" of the itmes covered in these proposals: 16 (b)-lobbying; 16 (c)-advertising; and 16 (f)-association dues. The Hearing Examiner is of the view that these items are subject to such distinction, and, with the exception noted hereafter with respect to 16 (f), the Hearing Examiner believes that the standards established with respect thereto are reasonable and necessary.

28. The last sentence of proposed 16 (f) engrafts upon the formula for association dues, a limitation that the cost of an activity undertaken by an association is allowable only if the cost of the same activity would be allowable to a nursing home if undertaken by such nursing home. This has not been demonstrated by the Department to be a reasonable or necessary limitation and should be deleted from the proposal.

29. With respect to proposed 16 (b) the Minnesota Association of Health Care Facilities (MAHCF), proposed that the words "and certified" be added after the word "license" so that the phrase would read "if lobbying directly relates to the licensed and certified functions of the facility". The Department concurred with this suggested change. The proposed amendment makes the original proposal more complete by allowing appropriate lobbying salaries in connection with both the federally "certified" functions of a nursing home as well as its state "licensed" functions. The proposed

amendment does not constitute a substantial change and should be added to the provision as originally proposed.

30. With respect to proposed 16 (e), the Department's proposal relating to legal fees, the Department has likewise attempted to establish a standard which distinguishes between "patient-care related components and nonpatient-care related components" of legal fees. The Department's proposal would, in essence, establish the following standard: legal fees are not directly related to patient care where the legal fees are "incurred in unsuccessful legal challenges where a government agency is a party to the suit". The Hearing Examiner does not believe that it is possible to establish criteria by which to measure whether a challenge to a decision by a state agency is directly related to the provision of patient care, and, accordingly, believes that the proposal is absurd. Further, even if it were possible to establish such a standard, the Department has not demonstrated the reasonableness of the standard which it has proposed.

31. The proposed amendment disallowing legal fees goes well beyond the scope of Minn. Stat. § 256B.47, Subd. 2. The amendment would disallow fees incurred in unsuccessful challenges from state agency decisions, as specified by the statute, but would also disallow fees incurred in any unsuccessful court challenge to a statute or regulation where the state agency is a party. Such challenges would not necessarily or even normally involve a "decision" by the agency. Also, the proposed amendment defines "unsuccessful challenge" to include those cases in which the nursing home does not demonstrate that it "clearly prevails" on the issues litigated. Such language would preclude the allowance of legal fees in the instance of a settled case although settlement might in fact represent the fruits of a clearly successful challenge.

Proposed Amendment to Rule 49 D 4 f -- Facilities Financed by Public Funds

32. Existing section D 4 f specifies that:

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

Minn. Stat. § 256B.43, Subd. 5, specifies that "Depreciation shall be allowed for all governmentally owned nursing homes regardless of the sources of the funds used to construct or expand the facility...." The proposed amendment specifies that the limitation of the current rule will not apply to government owned nursing homes, and the proposal is reasonable and necessary to bring the existing rule into conformance with Minn. Stat. § 256B.43, Subd. 5.

Proposed Amendment to Rule 49 D 6 a (5)-- Cost of Capital - Interest

33. The proposed amendment adds language to the existing rule to provide that interest expense for indebtedness incurred prior to April 13, 1976, by a non-proprietary or governmental owned nursing home is not subject to the limitations of the existing rule: 100 percent of the net asset value of the facility. This proposal is necessitated by the enactment of the Laws of Minnesota 1977, Chapter 453, Section 25, which provides that the existing law which limits the amount of interest recognizable as an allowable cost, Minn. Stat. § 256B.44, Subd. 2, shall not apply to the payments of interest indebtedness finally incurred prior to April 13, 1976, if the interest is otherwise allowable. The proposed amendment is in conformance with the 1977 enactment and is reasonable.

Proposed Amendment to Rule 49 D 6 A (6) -- Cost of Capital Interest

34. This proposal is intended to make the existing rule consistent with Minn. Stat. § 256B.44, Subd.3, which

specifies as follows:

> "A proprietary nursing home which pays interest on capital indebtedness at an interest rate in excess of 9 percent may be reimbursed for its expenses in excess of the 9 percent up to 12 percent if (1) the proceeds of the indebtedness are used for the purchase or operation of the nursing home and (2) the interest rate is not in excess of what a borrower would have to pay in an arms-length transaction at the time the loan was made."

The language of the original proposal generated a comment that the terminology was subject to conflicting interpretations. In response to such comment the Department proposed to modify the language of the proposal to read as follows:

> Interest expense for a proprietary nursing home will be allowable on capital indebtedness to the extent that the rate of interest exceeds 9 percent but no more than 12 percent if the indebtedness relates directly to the purchase of the nursing home or to working capital for the operation of the nursing home and if the rates of interest does not exceed a rate which a prudent and cost-conscious borrower would incur in an arms-length transaction.

This change clarifies the intent of the Department, consistent with Minn. Stat. § 256B.44, Subd. 3, that only capital indebtedness interest expense between 9 percent and 12 percent be allowed. The change also substitutes the language "facility" for "nursing home" to conform the language of the proposal with that of the statute. The proposed modification does not constitute a substantial change, and the proposal as modified is reasonable and necessary to bring the existing rule into conformance with Minn. Stat. § 256B.44, Subd. 3.

Proposed Amendment to Rule 49 D 6 b (1) -- Investment Allowance

35. This proposal constitutes an addition to the existing rule and is based upon Minn. Stat. § 256B.45, Subd. 2, which provides as follows:

> For each year after the year in which the nursing home was originally purchased in which there is no transfer of ownership of a nursing home, the investment allowance shall be increased by one percent of the original investment allowance, but the increases shall be limited to a maximum of 25 percent of the original investment allowance.

The proposal incorporates the increased investment allowance authorized by Minn. Stat. § 256B.45, Subd. 2, but limits it in instances where there has been a partial change in ownership according to D 4 a (2) (b) or the addition of beds to the facility since the date of original acquisition or purchase of the facility. The limitation with respect to change of ownership was proposed by the Department at the hearing as a modification to the original proposal. The Department suggested, in this connection, that the words "or a change in ownership occurs" be added after the phrase "existing bed compliment."

36. The limitation on the increased investment allowance in the case of the partial change of ownership was not opposed but was, in fact, generally supported. The Hearing Examiner is of the view that the proposed modification is reasonable and necessary and does not constitute a substantial change in view of the fact that the original proposal addressed the matter of adjustments where there has been a change in ownership. The suggested change makes the proposal internally consistent.

37. With respect to the limitation on the increased investment allowance where beds have been added to the facility since the date of purchase or acquisition of the facility, the Department asserted that the legislature intended to give an incentive allowance based only upon the number of beds existing at the time of purchase or acquisition. The Department, however, interpreted Minn. Stat. § 256B.45,

Subd. 2, to permit the increased investment allowance as to facility improvements which do not add beds. It appears to the Hearing Examiner that the legislature intended to reward continuity of ownership without regard to the type of improvements made at a facility. The Hearing Examiner is therefore, of the view that the proposed limitation is neither reasonable nor necessary.

38. The proposed amendment ties the definition of "original value of a facility" to D 4 B (1) which establishes original value for depreciation purposes. The Department did not offer any evidence or reason relating to the need or reasonableness of this part of the proposal.

39. In view of the foregoing, the entire proposal should be rejected and the language of the statute should be substituted.

Proposed Amendment to Rule 49 D 6 b (2) (a) -- Investment Allowance - Definition of "Facility"

40. The proposed amendment defines "fixture" for the purpose of giving meaning to the term "facility" in the context of a rule establishing an investment allowance related to the value of facilities. Minn. Stat. § 256B.42, Subd 2, defines "facility" as follows:

> "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.

Unfortunately, the legislature did not define the term "fixture". The definition of "fixture" is critical to nursing homes because of the large investment which they have in items unique to nursing home care, many of which are required by state and federal regulations. If such items are not included within the definition of "fixture", they are not included within the definition of "facility"

and, therefore, a nursing home is not entitled to an investment allowance in connection with such equipment. The debate at the instant hearing regarding this proposal, like the debate regarding a virtually identical proposal made by the Department in 1976, focused upon whether the definition of "fixtures" should be determined in accordance with commonly accepted principles of stationariness and/or fixation (Dept. Exhibit No. 1) or, rather, upon the basis of "special-purpose facility or plant" doctrines and the cost-related reimbursement principles underlying Rule 49 (written comment of M A H C F).

41. The Department presented no evidence with respect to the effect of the proposed definition upon facilities. Jack Brose, a CPA representing M A H C F, indicated in a written comment to the Hearing Examiner that the expansion and improvement of the industry would be in jeopardy under the proposal. Similarly, the Conference on Geriatric Care of the Minnesota Hospital Association indicated that it would be necessary to include moveable equipment which is an integral part of providing necessary nursing home services, especially equipment designed for specialized programs unique to long-term care, in the definition of "fixture" to insure the continued ability of nursing homes to provide adequate services during periods of rapidly inflating prices. A written comment of the Gold Medallion Nursing Centers also indicated that the proposed definition would have a tremendous negative impact on nursing homes.

42. It is not sufficient for the Department to rely upon legal authority which is only arguably applicable to the nursing home context to establish the reasonableness of its proposal. The Hearing Examiner does not mean to indicate that it is impossible for the Department to establish the reasonableness of its proposal by a showing of the effect

thereof upon nursing homes. The Department, however, has not done so, and the proposal should, therefore, be rejected as unreasonable. Finally, in view of the inability of the Department and the nursing home industry to resolve this debate in two lengthy hearings, it is suggested that the issue be returned to the legislature for determination or be litigated in order to avoid another rule making hearing with respect to the matter.

Proposed Amendment to Rule 49 D 6 b (3) -- Investment Allowance - Allowance for Leased Facilities

43. This proposal is an addition to Rule 49 and provides a "cost of capital allowance" to those facilities which have entered into lease agreements for the use of buildings and/or equipment and therefore are not eligible for the ownership investment allowance provided elsewhere in the rule. The allowance for leased facilities is calculated upon either patient-days or fixed assets owned by the lessee facility. The Department cited no statutory authority for such proposal, although it may properly be inferred that the legislature in establishing an investment allowance "for nursing homes" (Minn. Stat. § 256B.45) did not intend to restrict such allowance to owned facilities. There was no comment by the public on this proposal. The Hearing Examiner is, accordingly, of the view that the proposal to add a specific provision with respect to leased facilities is reasonable and necessary and that the methodology to be utilized in determining the allowance for leased facilities is reasonable.

Proposed Amendment to Rule 49 D 8 a -- Facility Utilization Incentives - Capacity Limitation

44. In an effort to do what the Department believes is responsive to Minn. Stat. § 256B.45, Subd. 1, which was

enacted in 1976 and which authorizes the Department to establish an investment allowance but specifies that "there shall be no other cost of capital or profit allowance for proprietary homes", the Department has proposed an amendment to Rule 49 similiar in purpose and effect to the proposal of the Department which was rejected by the Hearing Examiner in the 1976 Rule 49 hearing. The current rule provides that indirect costs may be divided by 93 percent of the total capacity patient days for licensed beds rather than by the actual occupancy. The effect of this provision is to enhance the financial return of facilities which have high occupancy. The Department claims that such enhancement constitutes profit and can not be allowed in view of the wording of Minn. Stat. § 256B.45, Subd. 1. The providers, on the other hand, believe that such enhancement represents a high occupancy "incentive" or an "incentive for utilization" and not additional profit. To illustrate the level of disagreement in the matter the Hearing Examiner took notice of the testimony of Mr. Kenneth Johnson, CPA, who testified that he felt that the existing 93 percent capacity limitation factor simply recognizes that there is a fixed portion of costs not related to occupancy and that the 93 percent figure was set as an average occupancy so that an overall equivalent overhead cost could be calculated. The appropriate classification of the "enhancement" to providers with 93 percent or greater occupancy is highly debatable and respectable authorities on both sides have failed to agree on what the correct definition is. However, the undisputed effect of the existing provision is to provide an incentive for a provider to increase his occupancy above 93 percent and thereby reduce patient day costs for such fixed items as depreciation, interest, property taxes and administrative expenses such as executive salaries.

45. The Hearing Examiner believes that the proposed amendment is unreasonable because it has not been clearly demonstrated by the Department that the current methodology creates a "profit allowance" within the meaning of Minn. Stat. § 256B.45, Subd. 1. Further, as in the case of the definition of "facility" discussed above, the Hearing Examiner suggests that the matter of the application of the terminology "profit allowance" to the capacity limitation or facility utilization incentive provided by the existing rule should be resolved legislatively or by litigation to avoid yet a third rule hearing in the matter.

46. The proposed amendment would apply to proprietary and non-proprietary homes alike. Clearly, the statute does not authorize application of the proposed limitation to non-proprietary homes, and, therefore, the proposal is without justification and is unreasonable.

47. The portion of the proposed amendment making the proposal effective on the first day of the month following adoption of the provision is reasonable and necessary. However, such finding is rendered moot by the foregoing findings with respect to the proposal as a whole.

Proposed Amendment to Rule 49 D 8 d (3) -- Facility Utilization Incentives - Average Length of Stay of 180 Days or Less

48. The proposed amendment replaces the language "actual patient days for the historical fiscal year" in the existing rule with the language "total discharge patient days for all years." The existing rule provides a methodology for the determination of "average length of stay" for purposes of waiver of certain capacity limitations for facilities which have an average length of stay of 180 days or less. The Department indicated that the proposal constituted a change in the current methodology of calculating actual patient days.

The Department indicated that one reason for the proposed change was the fact that the Office of Hearing Examiners had made recommendations for change. The Department, however, did not indicate what those recommendations were. In fact, Mr. Rau testified that the Hearing Examiners responsible for such "recommendation" indicated that the existing methodology was acceptable. Accordingly, it is impossible to conclude whether the proposed change is necessary for the reason given.

49. The Department also indicated that the proposed change is necessary to conform the terminology and/or methodology of the existing rule with that of the Department of Health. However, Mr. Rick Carter, Associate Director of the M A H C F, pointed out in his testimony that the Department of Public Welfare had apparently recently issued a bulletin re-defining "discharge". Mr. Rau confirmed seeing such a bulletin but did not know for certain whether it contained a definition of "discharge". Jack Brose indicated uncertainty with respect to the meaning of the term.

50. The chief defects in the Department's proposal in this matter are that the Department has not demonstrated the effect which the change in terminology and/or methodology may have upon providers, a fact objected to by the M A H C F, and the fact that the definition of the term "discharge" may prove to be difficult. In view of the foregoing, the Hearing Examiner is of the view that the Department has not demonstrated either the need for or the reasonableness of the proposed amendment.

Proposed Amendment to Minn. Rule 49 E 1 a - Implementation Procedures

51. The proposed amendment deals with implementation of the other proposed changes to Rule 49 and provides as follows:

Unless noted otherwise, all changes are effective for rates paid August 1, 1977, and subsequent.

The M A H C F expressed concern that the proposed language might suggest to providers that the Department would automatically adjust the rates paid to the providers to reflect the changes made in Rule 49 upon their adoption. This does not appear to be a real problem, however, in view of the Department's intention, expressed clearly and unequivocably at the hearing, that it would follow its current practice of informing all providers of the changes adopted and that it would point out to providers what they must do in order to take advantage of any changes.

CONCLUSIONS

1. Due, timely and adequate legal notice of the hearing was properly served and published by the Department. The argument of the M A H C F that it was entitled to be notified or consulted prior to the scheduling of the hearing in this matter is without merit.

2. The Department has complied with all substantive and procedural requirements of statute or rule except as noted at Findings of Fact No. 2 and 4.

3. The Department has documented its statutory authority to promulgate and the need for and reasonableness of the following proposals as originally proposed or, where applicable, as suggested to be amended by the Department or the Hearing Examiner:

49 B 4 a

49 C 1 c

49 C 1 g

49 D 2 a

49 D 3 d (16), (a), (b), (c), (d) and (f)

49 D 4 f

49 D 6 a (5)

49 D 6 a (6)

49 D 6 b (3)

49 E 1 a.

4. The Department has failed to demonstrate the need for and/or the reasonableness of the following proposals:

49 B 4 b

49 B 5 c

49 C 1 a (8)
49 D 3 d (16) (e)
49 D 6 b (1)

49 D 6 b (2) (a)

49 D 8 a

49 D 8 d (3).

RECOMMENDATIONS

1. The Hearing Examiner recommends that the rejection or withdrawal of the following proposals:

49 B 4 b

49 B 5 c

49 C 1 a (8)
49 D 3 d (16) (e)
49 D 6 b (1)

49 D 6 b (2) (a)

49 D 8 a

49 D 8 d (3).

2. The Hearing Examiner recommends adoption of the following proposals as originally proposed or, where applicable as suggested to be modified during the hearing:

49 B 4 a

49 C 1 c

49 C 1 g

49 D 2 a

49 D 3 d (16), (a), (b), (c), (d) and (f)

49 D 4 f

49 D 6 a (5)
49 D 6 a (6)
49 D 6 b (3)

49 E 1 a.

Dated this 18 day of January 1978.

Robert W. Herr
Hearing Examiner

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

Office Memorandum

TO : Lee Sheehy
Special Asst. Attorney General
Department of Administration

DATE: May 31, 1978

FROM : Paul Zerby
Deputy Attorney General
Department of Public Welfare

PHONE: 296-8403

RECEIVED
JUN 1 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

SUBJECT: DPW Rule 49

Pursuant to the requirements of Minn. Stat. 15.0412 Subd. 4, the Department of Public Welfare is submitting DPW Rule 49 for your approval as to form and legality.

If you have any questions concerning this submittal please call me at 6-8403

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OFFICE OF HEARINGS
EXAMINERS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

ORDER FOR HEARING

IT IS HEREBY ORDERED that a public hearing on the above-captioned rule be held in the State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Friday, October 21, 1977, commencing at 8:30 A.M. and continuing until all persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that the Notice of Hearing be published in the State Register.

Edward J. Dirkswager, Jr.

EDWARD J. DIRKSWAGER, JR.
Acting Commissioner

Date: September 9, 1977

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

NOTICE OF HEARING

NOTICE IS HEREBY GIVEN that a public hearing in the above-entitled matter will be held in the State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Friday, October 21, 1977, commencing at 8:30 A.M. and continuing until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Robert Herr, 308 Washington Square, White Bear Lake, Minnesota, 55110, telephone number 612-426-1661, either before the hearing or within five working days after the public hearing ends, or for a longer period not to exceed 20 days if ordered by the hearing examiner.

Present Rule 49 establishes the criteria by which welfare rates for nursing homes are established. The proposed amendments to Rule 49 implement 1977 Laws of Minnesota Chapters 326 and 453 pertaining to the allowability of depreciation expense or fixed assets, interest expense, investment allowance, rate limits, and to the conditions of participation in the Medical Assistance Program. The proposed amendments also clarify areas determined to be unclear as either the result of the appeal hearing process or agency rate discussions with nursing home providers and/or their representatives. Copies of the proposed rule are now available and one free copy may be obtained by writing to Jacqueline Bovaird, Department of Public Welfare, 1st Floor, Centennial Office Building, St. Paul, Minnesota, 55155. Additional copies will be available at the door on the date of the hearing. The agency's authority to promulgate the proposed rule is contained in Minn. Stat. Chapter 15, 246, 253A, 256 and 257. A "statement of need" explaining why the agency feels the proposed rule is necessary and a "statement of evidence" outlining the testimony they will be introducing will be filed with the Hearing Examiners Office at least 25 days prior to the hearing and will be available there for public inspection.

Please be advised that Minn. Stat., Chapter 10A, requires each lobbyist to register with the Ethical Practices Board within five days after he commences lobbying. Lobbying includes attempting to influence rule making by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 per year or five hours per month at lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota, 55155, phone 612-296-5615.

EDWARD J. DIRKSWAGER, JR.
Acting Commissioner

Dated: September 8, 1977

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EXAMINERS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

CERTIFICATE OF DELIVERY
SECRETARY
OF STATE'S LIST

I hereby certify that the attached 494 Labels & 6 sheets constitute the complete list of persons, associations and other interested groups who as of 1:15 o'clock P. M., this 14th day of September, 1977, have requested pursuant to M. S. 15.0412, that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

SECRETARY OF STATE

Joan Anderson Growe

By Cheri L. Mattson

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SEP 26 1977
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

AFFIDAVIT OF MAILING

Susan A. Wilford, being first duly sworn, deposes and says:

That on the 16 day of September, 1977, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of St. Paul, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the attached Certificate of the Secretary of State.

Susan A. Wilford

Subscribed and sworn to before me this

16 day of September, 1977.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY County
My Comm. Expires Sept. 15, 1977

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SEP 26 1977
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

ROBERT J. HAMPER, being duly sworn on oath deposes and says:

1) That he is an employee of the Special Services Division of the State of Minnesota, Department of Public Welfare.

2) That on the 14th day of September, 1977, he went to the Secretary of State's office for the State of Minnesota and requested a current list of all representatives of associations or other interested groups or persons who have registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules pursuant to M.S. 15.0412.

3) That on the 14th day of September, 1977, in response to the above request, the Secretary of State provided him with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Robert J. Hamper

Subscribed and sworn to before me this
17th day of September, 1977.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Commission Expires Sept. 30, 1977

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

RECEIVED
SEP 26 1977
OFFICE OF HEARING EXAMINERS

IN THE MATTER OF THE PROPOSED AMENDMENT OF MINN. RULE DPW 49 GOVERNING WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS UNDER THE TITLE XIX MEDICAL ASSISTANCE PROGRAM.

STATEMENT OF NEED

The above captioned rules are amended to existing rules of the Department of Public Welfare. The above captioned rules were most recently amended in public hearing on November 12-13, 1976.

The need to adopt these rules arises from the passage of Chapter 282, 1976 Laws of Minnesota and Chapters 326 and 453, 1977 Laws of Minnesota. There is also the need to adopt these rules to enhance the effective accountability of the rate formula pursuant to Minnesota Statutes, Sections 256B.27 and 256B.14, Subdivision 2.

The following specific changes to the rule are proposed for the indicated reasons:

1.) Minn. Rule DPW 49 B.4.a. is changed to include the provision that compliance with state laws may require limitation of welfare rates beyond the limitations already cited in the rule. Minn. Laws of 1976, Chapter 282, Section 8, Subdivision 1a. mandated certain conditions of participation in the Medical Assistance Program. This specific rule change is intended to implement that provision of the laws.

2.) Minn. Rule DPW 49 B.4.b. is changed to implement Chapter 282, Section 7, 1976 Laws of Minnesota which requires two overall rate limitations, one limitation for direct care costs and another limitation for indirect costs. The current Minn. Rule DPW B.4.b. contains an overall maximum rate of 125% of historical and prospectively projected costs identified according to geographical regions, types of ownership and levels of care. The proposed change continues the current methodology (utilized since July 1, 1973) of calculating the maximums by separating the reported allowable costs into the required two components and factoring the average cost per day by 125%. Current cost categories contained in the annually submitted Rule 49 cost reports are separated according to direct and indirect costs. The cost categories identified in the proposed rule as being either direct or indirect costs are those same costs which have been consistently recognized as direct or indirect costs.

3.) Minn. Rule DPW 49 B.5.c. is changed to clarify the time period for retroactive adjustment and collection of welfare rate overpayments based on audit by this agency. Historically this agency has effected welfare rates and made rate adjustments on temporary and interim rates according to Section B.2.a. Likewise this agency has made rate adjustments resulting from either desk audits where cost changes were not fully implemented or field audits according to Section B.2.c. The

proposed change will make it clear that retroactive adjustments for the issuance of temporary and interim rates will be effected prior to any appeal procedures and that retroactive adjustments based on a lack of implementation of cost changes and/or field audit adjustments will be continued pending resolution of the appeal.

4.) Minn. Rule DPW 49 C.1.a.(8) is added to the rule and requires the annual cost report to include an audited balance sheet and statement of revenues and expenses. Minn. Laws of 1976, Chapter 282, Section 8, Subdivision 2(a) directs nursing homes to provide audited balance sheets and statements of revenues and expenses in verification of Medical Assistance Program rate.

5.) Minn. Rule 49 C.1.c. is changed to include the provision that statistical and accounting records necessary to support information reported on the annual cost statements must be retained for at least three years following the submission of the annual cost report. This provision of the rule is necessary not only in conjunction with Section B.2.c. of the rule, but also it is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 11, Subdivision 2a.

6.) Minn. Rule DPW C.1.g. is changed to include the provision that all cost reports submitted in request of welfare rates will be subjected to field audit at least every three years. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 11, Subdivision 2a.

7.) Minn. Rule DPW 49 D.2.a. is changed to include the provision that nursing hour limitations will not be applied to those facilities which are required to provide additional nursing care based on a correction order issued by the Minnesota Department of Health. This provision of the rule is necessary for compliance with Minn.Laws of 1977, Chapter 326, Section 15, Subdivision 1.

8.) Minn. Rule DPW 49 D.3.d.(16)(a)-(f) are changed to include the provisions of specific cost allowances and/or disallowances for political contributions, salary of a lobbyist, advertising, Health Department assessments, legal fees and association dues. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 16, Subdivision 2.

9.) Minn. Rule DPW 49 D.4.f. is changed to include the provision that depreciation expense for governmentally-owned facilities will not be limited by receipt of public funds. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 12, Subdivision 5.

10.) Minn. Rule DPW 49 D.6.a.(5) is changed to include the provision which waives the interest expense limitation for indebtedness incurred prior to April 13, 1976 for non-profit facilities. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 453, Section 25.

11.) Minn. Rule DPW 49 D.6.a.(6) is changed to include the provision which modifies the interest expense allowance for proprietary facilities which have indebtedness at rates of interest between nine and twelve percent. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 13, Subdivision 3.

12.) Minn. Rule DPW 49 B.6.b.(1) is changed to include the provision which increases the investment allowance for all facilities for the years of continuous ownership of the facility. This provision of the rule is necessary for compliance with Minn. Laws of 1977, Chapter 326, Section 14, Subdivision 2.

13.) Minn. Rule DPW 49 D.6.b.(2)(a) is changed to include the provision which defines the word fixtures to mean that which is physically attached. This provision of the rule is necessary for the interpretation of Minn. Laws of 1976, Chapter 282, Section 2, Subdivision 2.

14.) Minn. Rule DPW 49 D.6.b.(3) is added to the rule to provide a cost of capital allowance to those facilities which have entered into lease agreements for the use of buildings and/or equipment and therefore are not eligible for the ownership investment allowance of Section D.6.b.(1).

15.) Minn. Rule DPW 49 D.8.a. is changed to include the provision which states the indirect costs, as previously identified in the rate methodology, will be divided by the greater of actual patient days or 93% of capacity days. The current rate methodology under this section of the rule contains a profit allowance by permitting the indirect costs to be divided by 93% capacity days by those facilities whose actual patient days exceed 93% of capacity days. This provision of the rule is necessary for the implementation of Minn. Laws of 1976, Chapter 282, Section 5, Subdivision 1.

16.) Minn. Rule DPW 49 D.8.d.(3) is changed to include the provision which defines an average length of stay as total discharge patient days, without regard for overlapping of fiscal years, divided by the total discharges for the cost reporting fiscal year. This provision of the rule is necessary for the implementation of certain recommendations made by the Office of Hearing Examiners.

17.) Minn. Rule DPW 49 E.1.a. is changed to reflect the effective dates of the proposed changes to the rule. Certain effective dates are required by Minn. Laws of 1977, Chapters 326 and 453. Other effective dates of the changes are established according to the adoption date of the proposed rule changes.

Acting Commissioner Public Welfare

Dated: September 23, 1977

Edward J. Dirkswager, Jr.

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

RECEIVED
SEP 26 1977
OFFICE OF HEARING EXAMINERS

IN THE MATTER OF THE PROPOSED AMENDMENT OF MINN. RULE DPW 49 GOVERNING WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS UNDER THE TITLE XIX MEDICAL ASSISTANCE PROGRAM.

STATEMENT OF EVIDENCE

In addition to the "Statement of Need" which is available for inspection or purchase at the Office of Hearing Examiners, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, and in support thereof the Department of Public Welfare will introduce the following evidence:

Testimony will be presented in explanation of the various proposed rule changes. There will be an identification of the conditions which led to the need for the proposed rule changes, including a summary of specific legislation, legislative intent and interpretation problems relating to the current rule.

The following expert witnesses will be available at the public hearing and may testify regarding any or all of the proposed rule changes: James Hiniker, Robert Rau and Richard Tester will explain each rule change and either indicate that it is required by law or that it is reasonably necessary as a change in the rate setting formula.

We intend to introduce the following manuals, books, scientific treaties, and other documentary evidence:

-Final Report of the Senate & House Select Committee on Nursing Homes.
-Minnesota Department of Health statistics for various reporting periods.
-Office of Hearing Examiner appeal recommendations from one or more contested cases.
-Appeal committee appeal recommendations from one or more contested cases.
-Annual computer statistical reports maintained by DPW;
-Public Hearing file from November 12-13, 1976 Minn. Rule DPW 49 rate setting hearing.

We will be citing the following statutes and case law:

-Minnesota Statutes, Chapter 15, and Minnesota Statutes, Chapter 256B, (1974).
-Minn. Laws of 1976, Chapter 282.

-Minn. Laws of 1977, Chapters 326 and 453.
-45 CFR 250.30.

Acting Commissioner of Public Welfare

Dated: September 23, 1977

Edward G. Dirkswager, Jr.

DPW-78-021-RH

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE DETERMINATION OF WELFARE PER-DIEM RATES FOR NURSING HOME PROVIDERS, UNDER TITLE XIX MEDICAL ASSISTANCE PROGRAM, RULE 49.

REPORT OF THE CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on October 21, 1977, and resumed on October 25, 1977, before Robert W. Herr, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 15.052, Subd. 3, was issued to the Department of Public Welfare on January 18, 1978; and

WHEREAS, the Department of Public Welfare has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the Department of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, Subd. 4, and Rule HE 107; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Public Welfare has met all requirements of Minn. Stat. § 15.0412, Subd. 4.

NOW, THEREFORE, upon receipt of this Report, the Department of Public Welfare has the responsibility of submitting the complete hearing record and the rules as adopted by the Department to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. § 15.0412, Subd. 4.

Dated this 26th day of May, 1978.

DUANE R. HARVES
Chief Hearing Examiner

STATEMENT OF COMPLIANCE WITH
MANUAL OF RULE MAKING PROCEDURES

I, Deputy Attorney General Paul Zerby, do hereby declare that I have examined the proposed rules and all related documents and that, based on them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed. Any exceptions are noted below.

Paul G Zerby
Deputy Attorney General

Dated: 6/1/78