CHAPTER 75-02-06
RATESETTING FOR NURSING HOME CARE

SECTION 1: Subsection 2 of section 75-02-06-12 is amended as follows:

75-02-06-12. Offsets to cost.

2. If actual costs are not identifiable, income must be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. Sources of income include:

a. "Activities income". Income from the activities department and the gift shop must be offset to activity costs.

b. "Dietary income". Amounts received from or on behalf of employees, guests, or other nonresidents for lunches, meals, or snacks must be offset to dietary and food costs.

c. "Drugs or supplies income". Amounts received from employees, doctors, or others not admitted as residents must be offset to nursing supplies. Medicare part B income for drugs and supplies must be offset to nursing supplies.

d. "Insurance recoveries income". Any amount received from insurance for a loss incurred must be offset against the appropriate cost category, regardless of when or if the cost is incurred, if the facility did not adjust the basis for depreciable assets.

e. "Interest or investment income". Interest received on investments, except amounts earned on funded depreciation or from earnings on gifts where the identity remains intact, must be offset to interest expense.

f. "Laundry income". All amounts received for laundry services rendered to or on behalf of employees, doctors, or others must be offset to laundry costs.

g. "Private duty nurse income". Income received for the providing of a private duty nurse must be offset to nursing salaries.

h. "Rentals of facility space income". Income received from outside sources for the use of facility space and equipment must be offset to property costs.

i. "Telephone income". Income received from residents, guests, or employees must be offset to administration costs. Income from emergency answering services need not be offset.

j. "Therapy income". Except for income from medicare part A, income from therapy services~~, including medicare part B income,~~ must be offset to therapy costs unless the provider has elected to make

therapy costs nonallowable under subsection 40 of section 75-02-06-12.1.

k. "Vending income". Income from the sale of beverages, candy, or other items must be offset to the cost of the vending items or, if the cost is not identified, all vending income must be offset to the cost category where vending costs are recorded.

l. "Bad debt recovery". Income for bad debts previously claimed must be offset to property costs in total in the year of recovery.

m. "Other cost-related income". Miscellaneous income, including amounts generated through the sale of a previously expensed or depreciated item, such as supplies or equipment, or the amount related to the default of a contractual agreement related to education expense assistance, must be offset, in total, to the cost category where the item was expensed or depreciated.

n. "Medicare part B income". Income from medicare part B must be offset to the cost category where the expense is recorded.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; June 1, 1988; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 2002; January 1, 2010; January 1, 2012; July 1, 2016; April 1, 2018.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 2: Section 75-02-06-12.1 is amended as follows:

75-02-06-12.1. Nonallowable costs.

Costs not related to resident care are costs not appropriate or necessary and proper in developing and maintaining the operation of resident care facilities and activities. These costs are not allowed in computing the rates. Nonallowable costs include:

1. Political contributions;

2. Salaries or expenses of a lobbyist;

3. Advertising designed to encourage potential residents to select a particular facility;

4. Fines or penalties, including interest charges on the penalty, bank overdraft charges, and late payment charges;

5. Legal and related expenses for challenges to decisions made by governmental agencies except for successful challenges as provided for in section 75-02-06-02.5;

6. Costs incurred for activities directly related to influencing employees with respect to unionization;

7. Cost of memberships in sports, health, fraternal, or social clubs or organizations, such as elks, country clubs, or knights of columbus;

8. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies (including all dues unless an allocation of dues to such costs is provided);

9. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., lions, chamber of commerce, or kiwanis, in excess of one thousand five hundred dollars per cost reporting period;

10. Home office costs not otherwise allowable if incurred directly by the facility;

11. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors that include annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for security exchange commission purposes, stock transfer agent fees, and stockholder and investment analysis;

12. Corporate costs not related to resident care, including reorganization costs; costs associated with acquisition of capital stock, except otherwise allowable interest and depreciation expenses associated with a transaction described in subsection 3 of section 75-02-06-07; and costs relating to the issuance and sale of capital stock or other securities;

13. The full cost of items or services such as telephone, radio, and television, including cable hookups or satellite dishes, located in resident accommodations, excluding common areas, furnished solely for the personal comfort of the residents;

14. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

15. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates, to

the satisfaction of the department, that any particular use of equipment was related to resident care;

16. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any hospital or facility;

17. Costs incurred by the provider's subcontractors, or by the lessor of property that the provider leases, that are an element in the subcontractor's or lessor's charge to the provider, if the costs would not have been allowable had the costs been incurred by a provider directly furnishing the subcontracted services, or owning the leased property except no facility shall have a particular item of cost disallowed under this subsection if that cost arises out of a transaction completed before July 18, 1984;

18. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises;

19. Depreciation expense for facility assets not related to resident care;

20. Nonnursing facility operations and associated administration costs;

21. Direct costs or any amount claimed to medicare for medicare utilization review costs;

22. All costs for services paid directly by the department to an outside provider, such as prescription drugs;

23. Travel costs involving the use of vehicles not exclusively used by the facility except to the extent:

    a. The facility supports vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care;

    b. Resident-care related vehicle travel costs do not exceed a standard mileage rate established by the internal revenue service; and

    c. The facility documents all costs associated with a vehicle not exclusively used by the facility;

24. Travel costs other than vehicle-related costs unless supported, reasonable, and related to resident care;

25. Additional compensation paid to an employee, who is a member of the board of directors, for service on the board;

26. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid, per day, to a member of the legislative council, pursuant to North Dakota Century Code section 54-35-10;

27. Travel costs associated with a board of directors meeting to the extent the meeting is held in a location where the organization has no facility;

28. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion of the cost which relates to costs that benefit all eligible employees;

29. Employment benefits associated with salary costs not includable in a rate set under this chapter;

30. Premiums for top management personnel life insurance policies, except that the premiums must be allowed if the policy is included within a group policy provided for all employees, or if the policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the sole beneficiary;

31. Personal expenses of owners and employees, including vacations, personal travel, and entertainment;

32. Costs not adequately documented through written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities;

33. The following taxes:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes on the issuance of bonds, property transfers, or issuance or transfer of stocks, which are generally

either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;

d. Taxes, including real estate and sales tax, for which exemptions are available to the provider;

e. Taxes on property not used in the provision of covered services;

f. Taxes, including sales taxes, levied against the residents and collected and remitted by the provider; and

g. Self-employment (FICA) taxes applicable to persons including individual proprietors, partners, members of a joint venture;

34. The unvested portion of a facility's accrual for sick or annual leave;

35. The cost, including depreciation, of equipment or items purchased with funds received from a local or state agency, exclusive of any federal funds, unless identified as an offset to cost exception in subdivision h of subsection 1 of section 12;

36. Hair care, other than routine hair care, furnished by the facility;

37. The cost of education unless:

a. The facility is claiming an amount for repayment of an employee's student loans related to educational expenses incurred by the employee prior to the current cost report year provided:

(1) The education was provided by an accredited academic or technical educational facility;

(2) The allowable portion of a student loan relates to education expenses for materials, books, or tuition and does not include any interest expense;

(3) The education expenses were incurred as a result of the employee being enrolled in a course of study that prepared the employee for a position at the facility, and the employee is in that position; and

(4) The facility claims the amount of student loan repayment assistance for work performed by the employee in the position for which the employee received education, provided the amount claimed per employee may not exceed

an aggregate of fifteen thousand dollars, and in any event may not exceed the cost of the employee's education.

b. The facility is claiming education expense for an individual who is currently enrolled in an accredited academic or technical educational facility provided:

(1) The education expense is for materials, books, or tuition;

(2) The facility claims the education expense in an amount not to exceed the individual's education expense incurred;

(3) The aggregate amount of education expense claimed for an individual over multiple cost report periods does not exceed fifteen thousand dollars; and

(4) The facility has a contract with the individual which stipulates a minimum commitment to work for the facility of six thousand six hundred fifty-six hours of employment after completion of the education program, as well as a repayment plan if the individual does not fulfill the contract obligations. The number of hours of employment required may be prorated for an individual who receives less than fifteen thousand dollars in assistance.

38. ~~Repealed effective January 1, 1999.~~

~~39.~~ Increased lease costs of a facility, unless:

a. The lessor incurs increased costs related to the ownership of the facility or a resident-related asset;

b. The increased costs related to the ownership are charged to the lessee; and

c. The increased costs related to the ownership would be allowable had the costs been incurred directly by the lessee;

~~40.~~39. At the election of the provider, the direct and indirect costs of providing therapy services to nonnursing facility residents, third party payer therapy services, or medicare part B therapy services, including purchase of service fees and operating or property costs related to providing therapy services;

~~41.~~40. Costs associated with or paid for the acquisition of licensed nursing facility capacity;

~~42.~~41. Goodwill;

~~43.~~42. Lease costs in excess of the amount allocable to the leased space as reported on the medicare cost report by a lessor who provides services to recipients of benefits under title XVIII or title XIX of the Social Security Act; ~~and~~

~~44.~~43. Salaries accrued at a facility's fiscal yearend but not paid within seventy-five days of the cost report yearend~~.~~;

~~45.~~44. Supplemental payments not offset to costs~~.~~; and

~~46.~~45. Alcohol and tobacco products.

History: Effective January 1, 1990; amended effective January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998; January 1, 1999; January 1, 2010; January 1, 2012; January 1, 2014; July 1, 2016; April 1, 2018.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 3: Section 75-02-06-16 is amended as follows:

75-02-06-16. Rate determinations.

1. For each cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by standardized resident days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate as calculated is compared to the limit rate for each cost category to determine the lesser of the actual rate or the limit rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to establish the direct care rate for that classification. The lesser of the actual rate or the limit rate for other direct care, indirect care, and property costs, and the adjustments provided for in subsection 2 and 3 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. a. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to seventy percent times the difference between the actual rate, exclusive of the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of two dollars and sixty cents or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs,

whichever is less, must be included as part of the indirect care cost rate.

b. A facility shall receive an operating margin of three percent based on the lesser of the actual direct care and other direct care rates, exclusive of the adjustment factor, or the limit rate in effect at the end of the year immediately preceding the rate year. The three percent operating margin must be added to the rate for the direct care and other direct care cost categories.

3. Limitations.

a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any time based upon information available.

b. The department shall review, on an ongoing basis, aggregate payments to facilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under medicare payment principles. If aggregate payments to facilities exceed estimated payments under medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under medicare payment principles.

c. All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in North Dakota Century Code section 50-24.4-13 must be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. The base year is the report year ended June 30, ~~2010~~2014. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

d. The limit rate for each of the cost categories must be established as follows:

(1) Historical costs for the report year ended June 30, ~~2010~~2014, as adjusted, must be used to establish rates for all facilities in the direct care, other direct care, and indirect care cost categories. The rates as established must be ranked from low to high for each cost category.

(2) For the rate year beginning ~~January1, 2013~~June 1, 2017, the limit rate for each cost category is:

(a) For the direct care cost category, one hundred ~~fifty-one~~seventy-eight dollars and ~~nineteen~~eighteen cents;

(b) For the other direct care cost category, ~~twenty-five~~ twenty-eight dollars and ~~forty-six~~fifteen cents; and

(c) For the indirect care cost category, ~~sixty-five~~seventy-seven dollars and ~~thirteen~~twenty-nine cents.

e. A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate.

f. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:

(1) Actual census for the report year; or

(2) Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:

(a) Multiplied times three hundred sixty-five; and

(b) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

g. The department may waive or reduce the application of subdivision f if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

(1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision f.

h. The department may waive the application of paragraph 2 of subdivision f for nongeriatric facilities for individuals with disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department-approved referrals or admissions.

4. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care under subsection 1 and for purposes of adjusting the limit rates for direct care costs, other direct care costs, and indirect care costs under subsection 3, but may not be used to adjust property costs under either subsection 1 or 3.

5. Rate adjustments.

a. Desk audit rate.

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. No decision on the request for reconsideration of the desk

rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

(5) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least ten cents per day for the rate weight of one.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least ten cents per day for the rate weight of one that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c.

(4) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(5) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least ten cents per day for the rate weight of one must

result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least ten cents per day for the rate weight of one had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) Adjustments resulting from an audit of home office costs, that result in a change of at least ten cents per day for the rate weight of one, must be included as an adjustment in the report year in which the costs were incurred.

(d) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject

to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least ~~twenty-five cents~~one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

6. Rate payments.

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate

must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

e. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically provided for in this section.

7. Partial year.

a. Rates for a facility changing ownership during the rate period are set under this subdivision.

(1) The rates established for direct care, other direct care, indirect care, operating margins, and incentives for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

(a) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; ~~and~~

(b) For a facility with less than four months of operation under the new ownership during the report year, by indexing the rates established for the previous owner forward using the adjustment factor in subsection 4; or

(c) If the change of ownership occurred after the report year end, but prior to the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(2) Unless a facility elects to have a property rate established under paragraph 3, the rate established for property for the previous owner must be retained through the end of the rate period and the property rate for the next rate period following the change in ownership must be established:

(a) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than four months of operation under the new ownership during the report year, by using the rate established for the previous owner for the previous rate year; or

(c) If the change of ownership occurred after the report year end, but prior to the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not

exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

b. For a new facility, the department shall establish an interim rate equal to the limit rates for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the property rate. The property rate must be calculated using projected property costs and projected census. The interim rate must be in effect for no less than ten months and no more than eighteen months. Costs for the period in which the interim rate is effective must be used to establish a final rate. If the final rates for direct care, other direct care, and indirect care costs are less than the interim rates for those costs, a retroactive adjustment as provided for in subsection 5 must be made. A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.

(1) If the effective date of the interim rate is on or after March first and on or before June thirtieth, the interim rate must be effective for the remainder of that rate year and must continue through June thirtieth of the subsequent rate year. The facility shall file by March first an interim cost report for the period ending December thirty-first of the year in which the facility first provides services. The interim cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate established based on the interim cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up. The cost reports for the report year ending June thirtieth of the current and subsequent rate years must be used to determine the final rate for the periods that the interim rate was in effect.

(2) If the effective date of the interim rate is on or after July first and on or before December thirty-first, the interim rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year. The facility shall file by March first an interim cost report for the period July first through December thirty-first of the subsequent rate year. The interim cost

report is used, along with the report year cost report, to determine the final rate for the periods the interim rate was in effect.

(3) If the effective date of the interim rate is on or after January first and on or before February twenty-ninth, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. The facility shall file a cost report for the period ending June thirtieth of the current rate year. This cost report must be used to establish the rate for the subsequent rate year. The facility shall file by March first an interim cost report for the period July first through December thirty-first of the current rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the period that the interim rate was in effect.

(4) The final rate for direct care, other direct care, and indirect care costs established under this subdivision must be limited to the lesser of the limit rate for the current rate year or the actual rate.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first day of the month beginning after the date the project is completed and placed into service or the first day of the month beginning after the date the request for a projected property rate is received by the department, whichever is later. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing prior to renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing prior to the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

d. For a facility with a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, must be applied to all licensed beds. An interim property rate must be established based on projected property costs and projected census. The interim property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health or the first day of the month beginning after the date when the request for a projected property rate is made to the department, whichever is later, through the end of the rate year. ~~The facility shall file by March first an interim property cost report following the rate year. The interim cost report is used to determine the final rate for property and to establish the amount for a retroactive cost settle-up. The final rate for property is limited to the lesser of the interim property rate or a rate based upon actual property costs.~~ The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year; and may not be subject to retroactive cost settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

e. For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

f. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

g. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subdivision c or d and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using subdivision c or d may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

8. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that must be increased to correct the deficiencies cited in the survey process.

(2) The facility shall submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health. The request must:

(a) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's certification survey;

(b) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and

(c) Provide a detailed list of any other costs necessary to meet survey standards.

(3) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted to an amount not to exceed the limit rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet major

unforeseeable expenses. The expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) Within sixty days after first incurring the unforeseeable expense, the facility shall submit a written request to the medical services division containing the following information:

(a) An explanation as to why the facility believes the expense was unforeseeable;

(b) An explanation as to why the facility believes the expense was beyond the managerial control of the facility; and

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on its background and knowledge of nursing care industry and business trends.

(4) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward not to exceed the limit rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 and when it has been determined the facility cannot meet the minimum

standards through reallocation of costs and efficiency incentives.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document, based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day;

(b) The facility shall document all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards; and

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received, including the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase must be divided by standardized resident days and the amount calculated must be added to the rate. This rate is subject to any rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in subsection 5.

(5) If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.

d. Adjustments for disaster recovery costs when evacuation of residents occurs.

(1) A facility may incur certain costs when recovering from a disaster such as a flood, tornado, or fire. If evacuation of

residents was necessary because of the disaster, actual recovery costs during the evacuation period, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs.

(2) When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning with the sixth month after the first resident is readmitted to the facility.

(3) Recovery costs must be identified as startup costs and included as passthrough costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph 4.

(4) If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

(5) Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty-month amortization period must be included as a reduction of deferred charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

9. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds ten cents per day for the rate weight of one.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; January 1, 2002; July 2, 2003; December 1, 2005; January 1, 2010; July 1, 2010; January 1, 2012; January 1, 2014; July 1, 2016; April 1, 2018.
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