CHAPTER 75-02-07.1
RATESETTING FOR BASIC CARE FACILITIES

SECTION 1. Section 75-02-07.1-01 is amended as follows:

75-02-07.1-01. Definitions.

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.
2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.
3. "Adjustment ~~factors~~ factor" means ~~indices used to adjust reported costs for inflation or deflation based on forecasts for~~ the inflation rate for basic

care services used to develop the legislative appropriation for the department for the applicable rate year.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.
5. "Aid to vulnerable aged, blind, and disabled persons" means a program that supplements the income of an eligible beneficiary who resides in a facility.
6. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by basic care regulations.
7. "Alzheimer's and related dementia facility" means a licensed basic care facility which primarily provides services specifically for individuals with Alzheimer's disease or related dementia.
8. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's-length transaction. It does not include:
   a. A purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 4 of section 75-02-07.1-13;
   b. A sale and leaseback to the same licensee;
   c. A transfer of an interest to a trust;
   d. Gifts or other transfer for nominal or no consideration;
   e. A change in the legal form of doing business;
   f. The addition or deletion of a partner, owner, or shareholder; or
   g. A sale, merger, reorganization, or any other transfer of interest between related organizations.
9. "Building" means the physical plant, including building components and building services equipment, licensed as a facility and used directly for resident care, and auxiliary buildings including sheds, garages, and storage buildings if used directly for resident care.
10. "Capital assets" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.
11. "Chain organization" means a group of two or more basic care or health care facilities owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to basic care or health care.
12. "Close relative" means an individual whose relationship by blood, marriage, or adoption to an individual who is directly or indirectly affiliated with, controls, or is controlled by a facility is within the third degree of kinship.
13. "Community contribution" means contributions to civic organizations and sponsorship of community activities. It does not include donations to charities.

14. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, determination of cost limitations, and determination of rates.
15. "Cost center" means a division, department, or subdivision thereof, group of services or employees, or both, or any unit or type of activity into which functions of a facility are decided for purposes of cost assignment and allocations.
16. "Cost report" means the department-approved form for reporting costs, statistical data, and other relevant information of the facility.
17. "Department" means the department of human services.
18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.
19. "Depreciation" means an allocation of the cost of a depreciable asset over its estimated useful life.
20. "Depreciation guidelines" means the American hospital association's depreciation guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised ~~1998~~ 2008 edition.
21. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.
22. "Direct care costs" means the cost category for allowable resident care, activities, social services, and laundry costs.
23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.
24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the facility premises.
25. "Eligible beneficiary" means a facility resident who is eligible for aid to vulnerable aged, blind, and disabled persons.
26. "Employment benefits" means fringe benefits and other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.
27. "Facility" means a provider licensed as a basic care facility, not owned or administered by state government, ~~and~~ which does not meet the definition of an Alzheimer's and related dementia facility, traumatic brain injury facility, or institution for mental disease, which is enrolled with the department as a basic care assistance program provider.
28. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.
29. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.
30. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

31. "Food and plant costs" means the cost category for allowable food, utilities, and maintenance and repair costs.
32. "Freestanding facility" means a facility that does not share basic services with a hospital-based provider or a nursing facility.
33. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits, uniform allowances, and medical services furnished at facility expense.
34. "Highest market-driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.
35. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.
36. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.
37. "In-house resident day" for basic care, swing bed, and nursing facilities means a day that a resident was actually residing in the facility. "In-house resident day" for hospitals means an inpatient day.
38. "Institution for mental disease" means a facility with a licensed capacity of seventeen or more beds which provides ~~diagnosis,~~ treatment~~,~~ or services primarily to individuals with a primary diagnosis of mental disease.
39. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.
40. "Limit rate" means the rate established as the maximum allowable rate for direct care and indirect care.
41. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.
42. "Medical care leave day" means any day that a resident is not in the facility but is in a licensed health care facility, including a hospital, swing bed, nursing facility, or transitional care unit, and is expected to return to the facility.
43. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.
44. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.
45. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

46. "Personal care rate" means the sum of the rates established for direct personal care costs, indirect personal care costs, and the operating margin for personal care.
47. "Private-pay resident" means a resident on whose behalf the facility is not receiving any aid to vulnerable aged, blind, and disabled persons program payments and whose payment rate is not established by any governmental entity with ratesetting authority.
48. "Private room" means a room equipped for use by only one resident.
49. "Property costs" means the cost category for allowable real property costs and passthrough costs.
50. "Provider" means the organization or individual who has executed a provider agreement with the department.
51. "Rate year" means the year from July first through June thirtieth.
52. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.
53. "Related organization" means a close relative or person or an organization which a provider is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists when an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.
54. "Report year" means the provider's fiscal year ending during the calendar year immediately preceding the rate year.
55. "Resident" means a person who has been admitted to the facility but not discharged.
56. "Resident day" in a facility means any day for which service is provided or for which payment in any amount is ordinarily sought, including medical care leave and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought. The amount of remuneration has no bearing on whether a day should be counted as a resident day. "Resident day" for assisted living or any other residential services provided means a day for which payment is sought by the provider regardless of remuneration.
57. "Room and board rate" means the sum of the rates established for property costs, direct room and board costs, indirect room and board costs, the operating margin for room and board, and food and plant costs.
58. "Routine hair care" means hair hygiene which includes grooming ~~and~~, shampooing, cutting, and setting.
59. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever

is greater. It does not mean an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds. It does not mean an increase in a facility's capacity resulting from converting beds formerly licensed as nursing facility beds.

60. "Specialized facility for individuals with mental disease" means a licensed basic care facility with a licensed capacity of less than seventeen which provides ~~diagnosis,~~ treatment~~,~~ or services primarily to individuals with mental disease.

61. ~~"Statewide minimum room and board rate" means a rate calculated based on the sum of the maximum amount of supplemental security income an eligible individual can receive as of the beginning of the rate year less sixty dollars multiplied by twelve and then divided by three hundred sixty-five.~~

~~62.~~ "Therapeutic leave day" means any day that a resident is not in the facility or in a licensed health care facility.

~~63.~~62. "Top management personnel" means corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

~~64.~~63. "Traumatic brain injury facility" means a licensed basic care facility which primarily provides services to individuals with traumatic brain injuries.

~~65.~~64. "Working capital debt" means debt incurred to finance facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000; July 1, 2001; February 1, 2007; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 2. Subsections 2 and 4 of section 75-02-07.1-02 are amended as follows:

2. Accounting and reporting requirements.
   a. The accrual basis of accounting, in accordance with generally accepted accounting principles, must be used for cost reporting purposes. A facility may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at yearend and when subsequently reported. Ratesetting procedures must prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles.
   b. To properly facilitate auditing, the accounting system must be maintained in a manner that allows cost accounts to be grouped by cost category and readily traceable to the cost report.

c. No later than the last day of the third month following the facility's fiscal yearend, except as provided for in subdivision d, each facility shall provide to the department:

(1) A cost report on forms prescribed by the department.

(2) A copy of the facility's financial statement. For provider organizations that operate more than one facility, a consolidated financial report can be provided. The information must be reconciled to each facility's cost report.

(3) A statement of ownership for the facility, including the name, address, and proportion of ownership of each owner.

(a) If a privately held or closely held corporation or partnership has an ownership interest in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the facility's cost report must be identified regardless of the proportion of ownership interest.

(b) If a publicly held corporation has an ownership interest of fifteen percent or more in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of ten percent or more.

(4) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the facility or a certification that the content of any such document remains unchanged since the most recent statement given pursuant to this subsection.

(5) Supplemental information reconciling the costs on the financial statements with costs on the cost report.

(6) The following information, upon request by the department:

(a) Access to certified public accountant's workpapers that support audited, reviewed, or compiled financial statements.

(b) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs.

(c) Separate financial statements for any organization, excluding individual facilities of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

(d) Separate financial statements for any organization with which the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

d. A facility may elect to file a cost report based on a December thirty-first report year or a June thirtieth report year, rather than on the facility's fiscal yearend. Once elected, the facility may not change the reporting period without written approval from the department. The due date for the information required in subdivision c will be March thirty-first if the facility elects a December thirty-first report year and September thirtieth if the facility elects a June thirtieth report year.

e. ~~In the event~~ If a facility fails to file the required cost report on or before the due date, the department may reduce the current payment rate to eighty percent of the facility's most recently established rate. Reinstatement of the current payment rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

f. A facility shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any cost report when the information filed is incomplete or inaccurate. If a cost report is rejected, the department may reduce the current payment rate to eighty percent of its most recently established rate until the information is completely and accurately filed.

g. Costs reported must include total costs and be adjusted to allowable costs. Adjustments made by the department, to attain allowable cost, may, if repeated on future cost filings, be considered as possible fraud and abuse. The department may forward all such items identified to the appropriate investigative group.

h. The department may grant an extension of the reporting deadline to a facility for good cause. To receive an extension, a facility shall submit a written request to the department. The deadline for filing may not be extended past April fifteenth of the year following the report year.

4. Penalties for false reports.

a. A false report is one where a facility knowingly supplies inaccurate or false information in a required report that results in an overpayment. If a false report is received, the department may:

(1) Immediately adjust the facility's payment rate to recover the entire overpayment within the rate year;

(2) Terminate the department's agreement with the provider;

(3) Prosecute under applicable state or federal law; or
(4) Use any combination of the foregoing actions.

b. The department may determine a report is a false report if a provider claims previously adjusted costs as allowable costs. ~~Previously adjusted costs being appealed must be identified as nonallowable costs.~~ Previously adjusted costs being appealed must be identified as nonallowable costs. The provider may indicate that the costs are under appeal and not claimed under protest to perfect a claim if the appeal is successful.

History: Effective July 1, 1996; amended effective October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 3. Subsections 6 and 7 of section 75-02-07.1-04 are amended as follows:

6. If a facility does not comply with ~~provisions of~~ this section, the department, if extreme hardship to the residents would otherwise result, may continue to make medical assistance and aid to vulnerable aged, blind, and disabled persons program payments to the facility for a period not to exceed ninety days from the date of mailing a written notice of a violation of this section. The facility may seek reconsideration of or appeal the department's action.
7. A facility may charge a higher rate for a private room used by an eligible beneficiary if:
   a. The private room is not necessary to meet the eligible beneficiary's care needs;
   b. The eligible beneficiary, or a person acting on behalf of the eligible beneficiary, has requested the private room;
   c. The facility informs the individual making the request, at the time of the request, of the amount of payment and that the payment must come from sources other than the eligible beneficiary's monthly income;
   d. The payment does not exceed the amount charged to private-pay individuals for use of a private room; and
   e. ~~Effective January 1, 2002, appropriate~~ Appropriate semiprivate accommodations are available at the time the first charges for a private room apply.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 4. Section 75-02-07.1-06 is amended as follows:

75-02-07.1-06. Direct care costs. Direct care costs include only those costs identified in this section.

1. **Resident care.**
   a. Salary and employment benefits for the director or supervisor of resident care staff, ~~resident care supervisors, inservice~~ in-service trainers for resident care staff~~, registered nurses, licensed practical nurses~~, quality assurance personnel, resident care aides, medication aides, ~~speech, occupational, and physical therapists~~ and ward clerks.
   b. Routine hair and personal hygiene items and services ~~necessary to meet the needs of~~ furnished routinely and relatively uniformly to all residents~~, including hair hygiene supplies, combs, brushes, soap, razors, shaving cream, toothbrush, toothpaste, denture adhesive, dental floss, moisturizing lotion, tissues, deodorant, sanitary napkins, towels, washcloths, nail hygiene services, bathing, and personal laundry~~; items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities; and items used by individual residents that are reusable, vary by the needs of an individual, and are expected to be available in the facility.
   c. ~~The cost of supplies used to provide therapy, or noncapitalized therapy or resident care equipment.~~
   ~~d.~~ Medically necessary items, services, and durable medical equipment which could otherwise be billed directly to medicaid if the facility chooses to provide them.
2. **Licensed Healthcare Professionals.**
   a. Salary and employment benefits for the director or supervisor of licensed healthcare professional staff, registered nurses, licensed practical nurses, speech, occupational, and physical therapists.
   b. The cost of supplies used to provide therapy, or noncapitalized therapy and resident care equipment.
3. **Laundry.**
   a. Salary and employment benefits for a director of laundry, laundry aides, seamstresses, and other personnel who gather, transport, sort, and clean linen and clothing.
   b. The cost of laundry supplies including detergents, softeners, and linens.
   c. Contracted services for laundry.

~~3.~~4. **Social services.** Salary and employment benefits or consultant fees for social workers or social worker designees.

~~4.~~5. **Activities.**
   a. Salary and employment benefits for activities director, activities aides, and other personnel who directly provide for leisure and recreational activities.

b. The cost of leisure and recreational activities and supplies including games, ceramics, pets, out-of-house activities, and noncapitalized exercise equipment.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 5. Subsection 1 of section 75-02-07.1-09 is amended as follows:

75-02-07.1-09. Cost allocations.

1. Direct costing of allowable costs must be used whenever possible. For a facility that cannot direct cost, the following allocation methods must be used:
   a. If a facility is combined with other residential or health care facilities, except for a nursing facility, the following allocation methods must be used:
      (1) Resident care salaries that cannot be reported based on actual costs must be allocated using time studies. Time studies must be conducted at least semiannually for a two-week period or quarterly for a one-week period. Time studies must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibilities. Allocation percentages based on the time studies must be used starting with the next pay period following completion of the time studies or averaged for the report year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, resident care salaries must be allocated based on revenues for resident services.
      (2) Salaries for a director or supervisor of resident care or ~~resident care supervisors~~ or licensed healthcare professionals that cannot be reported based on actual costs or time studies must be allocated based on resident care salaries ~~or~~, licensed healthcare professional salaries or full-time equivalents of resident care staff, or licensed healthcare professional staff.
      (3) Salaries for cost center supervisors must be allocated based on cost center salaries or full-time equivalents of supervised staff.
      (4) Other resident care costs must be allocated based on resident days.
      (5) Dietary and food costs must be allocated based on the number of meals served or in-house resident days.
      (6) Laundry costs must be allocated on the basis of pounds of laundry or in-house resident days.

(7) Activity costs must be allocated based on in-house resident days.
(8) Social service costs must be allocated based on resident days.
(9) Housekeeping costs must be allocated based on weighted square footage.
(10) Plant operation costs must be allocated based on weighted square footage.
(11) Medical records costs must be allocated based on the number of admissions or discharges and deaths.
(12) Pharmacy costs for consultants must be allocated based on in-house resident days.
(13) Administration costs must be allocated on the basis of the percentage of total adjusted cost, excluding property, administration, chaplain, and utility costs, in each facility.
(14) Property costs must be allocated first to a cost center based on square footage. The property costs allocated to a given cost center must be allocated using the methodologies set forth in this section for that particular cost center.
(15) Chaplain costs must be allocated based on the percentage of total adjusted costs, excluding property, administration, and chaplain.
(16) Employment benefits must be allocated based on the ratio of salaries to total salaries.

b. If any of the allocation methods in subdivision a cannot be used by a facility, a waiver request may be submitted to the department. The request must include an adequate explanation as to why the referenced allocation method cannot be used by the facility. The facility shall also provide a rationale for the proposed allocation method. Based on the information provided, the department shall determine the allocation method used to report costs.

c. Malpractice, professional liability insurance, therapy salaries, and purchased therapy services must be direct costed.

d. The costs of operating a pharmacy may not be included as facility costs.

e. For purposes of this subsection, "weighted square footage" means the allocation of the facility's total square footage, excluding common areas, identified first to a cost category and then allocated based on the allocation method described in this subsection for that cost category.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 6. Section 75-02-07.1-14 is amended as follows:

75-02-07.1-14. Compensation.

1. Compensation on an annual basis for top management personnel must be limited, prior to allocation, if any, to the greatest of:
   a. The highest market-driven compensation of an administrator employed by a freestanding not-for-profit facility during the report year;
   b. Sixty thousand nine hundred seventy-four dollars; or
   c. The limit set under this subsection for the previous rate year adjusted by the ~~increase~~ adjustment factor~~, if any, in the consumer price index, urban wage earners and clerical workers, all items, United States city average; or~~
   ~~c. Thirty-three thousand seven hundred eighty-five dollars~~.
   d. If the facility is combined with a nursing facility, the compensation limit for top management personnel as determined by chapter 75-02-06, except the allocation of the compensation to the basic care facility may not exceed the greatest of subdivision a, b, or c.
2. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation described in subsection 1, divided by three hundred sixty-five times the number of calendar days the individual was employed.
3. Compensation includes:
   a. Salary for managerial, administrative, professional, and other services;
   b. Amounts paid for the personal benefit of the person, e.g., housing allowance, flat-rate automobile allowance;
   c. The cost of assets and services the person receives from the provider;
   d. Deferred compensation, pensions, and annuities;
   e. Supplies and services provided for the personal use of the person;
   f. The cost of a domestic or other employee who works in the home of the person; or
   g. Life and health insurance premiums paid for the person and medical services furnished at facility expense.
4. Reasonable compensation for a person with at least five percent ownership, persons on the governing board, or any person related within the third degree of kinship to top management personnel must be considered an allowable cost if services are actually performed and required to be performed. The amount to be allowed must be an amount determined by the department to be equal to the amount required to be paid for the same services if provided by a nonrelated employee to a North Dakota facility. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the facility would have to employ another person to perform them. Reasonable hourly compensation may not exceed the amount determined under subsection 1, divided by two thousand eighty.

5. Costs otherwise nonallowable under this chapter may not be included as compensation.

~~6. The increase in the consumer price index means the percentage by which that consumer price index for the month of March, as prepared by the United States department of labor, exceeds that index for the month of March of the preceding year.~~

History: Effective July 1, 1996; amended effective July 1, 1998; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 7. Subsection 8 of section 75-02-07.1-15 is amended as follows:

8. The department shall establish a cost basis limitation for construction or renovation of a facility. A per bed cost limitation must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation, or remodeling.
   a. Effective August 1, 2009, the per bed limitation basis for double occupancy is $112,732.
   b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by one and a half.
   c. The existing per bed limitations for single and double occupancy must be adjusted annually on July first, using the increase, if any, in the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May 31st.
   d. The per bed limitations in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.
   e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitations .

History: Effective July 1, 1996; amended effective July 1, 1998; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 8. Section 75-02-07.1-20 is amended as follows:

75-02-07.1-20. Rate calculation.

1. For each cost category, the actual rate is calculated using allowable historical operating costs plus adjustment factors provided for in section 75-02-07.1-21 for the direct care, indirect care, and food and plant cost categories, divided by in-house resident days for the direct care and

indirect care cost categories and resident days for the food and plant and property cost categories. The actual rate as calculated for direct care and indirect care is compared to the limit rate for each category to determine the lesser of the actual rate or the limit rate. The lesser of the actual rates or the limit rates for direct care and indirect care ~~costs~~ cost categories and the operating margin provided ~~for~~ in section 75-02-07.1-22 are added to establish the facility's personal care rate. The rates for property costs ~~and~~ , food and plant costs, and the lesser of the actual rates or the limit rates for direct room and board, indirect room and board costs are added to establish the facility's room and board rate. The sum of the personal care rate and the ~~actual~~ room and board rate is the facility's established rate.

2. The established rate for a licensed nursing facility providing services to an eligible beneficiary is:
   a. For a nursing facility that shares basic services with a licensed basic care facility, the rate established for the licensed basic care facility as provided for in subsection 1; and
   b. For a nursing facility that does not share basic services with a licensed basic care facility, the sum of the limit rates for direct care and indirect care costs, the maximum three percent operating margin calculated in section 75-02-07.1-21, and a ~~room and board~~ rate calculated using allowable food and plant and property costs and census used in establishing the nursing facility's current rate under chapter 75-02-06.

~~3. If the actual room and board rate component of an established rate calculated using the provisions of subsection 1 or 2 is less than the statewide minimum room and board rate, the actual room and board rate component of the established rate shall be increased to the statewide minimum room and board rate and the personal care rate component of the established rate shall be decreased by the same amount.~~

History: Effective July 1, 1996; amended effective July 1, 1999; July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 9. Section 75-02-07.1-21 is amended as follows:

75-02-07.1-21. Adjustment ~~factors~~ factor for direct care, indirect care, and food and plant costs. ~~Adjustment factors shall be applied to adjust historical allowable costs. The adjustment factor applied shall not exceed the lesser of the inflation factor allowed by the legislative assembly or the increase, if any, in the consumer price index, urban wage earners and clerical workers, all items, United States city average. The increase in the consumer price index means the percentage by which that consumer price index for the month of March, as prepared by the United States department of labor, exceeds that index for the month of March of the preceding year. The adjustment factor must be used to adjust direct care, indirect care, and food and plant costs. Costs reported for a period other than twelve months ended December thirty-first of a report year must be adjusted to December thirty-first of a report year using the increase, if any,~~

~~in the consumer price index, urban wage earners and clerical workers, all items, United States city average, over the period ending December thirty-first of the report year, and beginning at the end of the month within which the report period ends.~~

1. The adjustment factor will be applied to adjust historical costs. The adjustment factor will be used to adjust direct care, indirect care, and food and plant costs.
2. Costs reported for a period other than twelve months ended December thirty-first of a report year will be adjusted to December thirty-first using:
   a. The increase, if any, in the consumer price index, urban wage earners and clerical workers, all items, United States city average, over the period ending December thirty-first of the report year, and beginning at the end of the month within which the report period ends.
   b. The increase, if any, identified in subsection a of this section shall be applied prior to any application of the adjustment factor.

History: Effective July 1, 1996; amended effective July 1, 2001; July 2, 2002; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 10. Section 75-02-07.1-22 is amended as follows:

75-02-07.1-22. Rate limitations.

1. Historical costs, as adjusted, for all facilities for which a rate is established excluding specialized facilities for individuals with mental disease, must be used in the establishment of a limit rate for the direct care and indirect care cost categories. The actual rate for each cost category for each facility must be determined in accordance with this chapter. The department shall, for each cost category, rank licensed beds in all facilities reporting historical costs, excluding specialized facilities for individuals with mental disease, by the actual rate and determine the position in the ranking below which lie eighty percent of the ranked beds. For each cost category, the rate associated with the position ranked at eighty percent of the ranked beds is the limit rate for that cost category. When establishing a facility's rate:
   a. Except for a specialized facility for individuals with mental disease, a facility with an actual rate that exceeds the limit rate for direct care cost category shall receive the limit rate for that cost category;
   b. A specialized facility for individuals with mental disease with an actual rate that exceeds two times the limit rate for the direct care cost category shall receive the limit rate times two for that cost category; and
   c. A facility with an actual rate that exceeds the limit rate for the indirect care cost category shall receive the limit rate for that cost category.

~~2. If at any time the total number of licensed basic care beds in North Dakota exceeds one thousand three hundred eighty-two, before the beginning of~~

~~each quarter beginning thereafter, the department shall review the sufficiency of appropriations provided to pay the estimated cost of supplements. If the appropriations appear insufficient, the department shall determine reduced rates for all facilities with substantial capacity increases and for all new facilities.~~

~~3. The reduced rate for each facility subject to a reduced rate is determined by:~~

~~a. Establishing the total appropriation available for supplements during that reduced rate quarter;~~

~~b. Projecting the number of beds, in all facilities with substantial capacity increases and all new facilities, that will likely be occupied by persons eligible for a supplement during the reduced rate quarter;~~

~~c. Projecting expenditures for supplements, for that reduced rate quarter, in all facilities not subject to reduced rates;~~

~~d. Projecting expenditures for supplements, during a reduced rate quarter, that would be made in all facilities with substantial capacity increases and in all new facilities, if those facilities were not subject to limits;~~

~~e. Subtracting the amount projected under subdivision c from the amount determined under subdivision a;~~

~~f. Subtracting the amount determined under subdivision e from the amount projected under subdivision d;~~

~~g. Dividing the amount determined under subdivision f by the number projected under subdivision b; and~~

~~h. Reducing the established rate set for that facility by the amount determined under subdivision g.~~

~~4. A facility is not subject to reduced rates if it is not a new facility or if it has not been subject to a substantial capacity increase. All new facilities and all facilities subject to a substantial capacity increase are subject to reduced rates.~~

~~5. A reduced rate is effective during the reduced rate quarter for which it is established.~~

~~6. A facility subject to a reduced rate must be informed of the reduced rate no later than the usual date supplement payment is made to the facility for services furnished during the first month of the reduced rate quarter.~~

~~7. A facility shall receive an operating margin of three percent based on the lesser of the actual direct care rate, exclusive of the adjustment factor, or the direct care limit rate, exclusive of the adjustment factor, established for the rate year. For purposes of this subsection, the adjustment factor does not include the factor necessary to adjust reported costs to December thirty-first.~~

~~8. For purposes of this section:~~

~~a. "New facility" means a facility for which no rate was set, under this chapter, for any period before July 1, 1995.~~

~~b. "Quarter" means one of the four periods occurring in each calendar year, beginning January first and ending March thirtieth, beginning April first and ending June thirtieth, beginning July first and ending September thirtieth, or beginning October first and ending December thirty-first.~~

~~c. "Substantial capacity increase" means a capacity increase to a licensed capacity six or more licensed beds greater than a facility's licensed capacity on July 1, 1995, or a capacity increase to a licensed capacity equal to or greater than one and one-tenth times that facility's licensed capacity on July 1, 1995, whichever is less.~~

~~d. "Supplement" means payments provided or the provision of payments under North Dakota Century Code chapter 50-24.5.~~

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 1999; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; amended July 1, 2001; February 1, 2007; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 11. Subsection 2 of section 75-02-07.1-24 is amended as follows:

2. The department may supplement the income of an eligible beneficiary receiving necessary basic care services only if the lowest rate charged to private-pay residents ~~for semiprivate accommodations~~ equals or exceeds the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to an eligible beneficiary for the same bed type, including medical leave or therapeutic leave days.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 12. Subsections 1 and 11 of section 75-02-07.1-25 are amended as follows:

1. For a new facility, the department shall establish an interim rate equal to the lesser of the limit rates for direct and indirect care for the rate year in which the facility begins operation, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. No retroactive adjustment may be made to the rate.
   a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be

effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. ~~The~~ By August thirty-first, the facility shall file an interim cost report by ~~August thirty-first~~ for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

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

c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. ~~The~~ By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

11. A facility that meets the definition of a specialized facility for individuals with mental disease as a result of a reduction in licensed capacity to less than seventeen may choose to have an interim rate established for the remainder of the rate year following the capacity decrease and the subsequent rate based on the lesser of the limit rates for a specialized facility for individuals with mental disease for the rate year in which the institution for mental disease decreases its licensed capacity, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. Retroactive adjustments may not be made to the rate.

a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. ~~The~~ By August thirty-first, the facility shall file an interim cost report ~~by August thirty-first~~ for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

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

c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. ~~The~~ By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; February 1, 2007; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

SECTION 13. Section 75-02-07.1-26 is amended as follows:

75-02-07.1-26. One-time adjustments.

1. **Adjustments to meet licensure standards.**
   a. The department may provide for an increase in the established rate for additional costs incurred to meet licensure 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 or other costs increased to correct the deficiencies cited in the survey process.
   b. The facility shall submit a written request to the department within thirty days of submitting the plan of correction to the state department of health. The request must:
      (1) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's licensure survey;
      (2) Identify the number of new staff or additional staff hours and the associated costs required to meet the licensure standards;
      (3) Provide a detailed list of any other costs necessary to meet licensure standards;
      (4) Describe how the facility shall meet licensure standards if the adjustment is received, including the number and type of staff to be added to the current staff and the projected salary and fringe benefit cost for the additional staff; and

(5) Document that all available resources, including efficiency incentives, if used to increase staffing, are not sufficient to meet licensure standards.

c. The department shall review the submitted information and may request additional documentation or conduct onsite visits.

d. If an increase in costs is approved, the adjustment must be calculated based on the costs necessary to meet licensure standards less any incentives included when calculating the established rate. The net increase must be divided by resident days and the amount calculated must be added to the established rate. This rate must then be subject to any rate limitations that may apply.

e. 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 that the funds were not used for the intended purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

f. If the actual cost of implementation exceeds the amount included in the adjustment, no retroactive settlement may be made.

2. **Adjustments for unforeseeable expenses.**

a. 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 beyond the control of those responsible for the management of the facility.

b. Within sixty days after first incurring the unforeseeable expense, the facility shall submit to the department a written request containing:

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

(2) An explanation as to why the facility believes the expense was beyond the managerial control of the owner or administrator of the facility; and

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

c. 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 their background and knowledge of basic care industry and business trends.

d. 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.

e. 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 section 75-02-07.1-23.

3. **Adjustments for salary and benefit enhancements.**
   a. The department may provide for a salary and benefit enhancement rate.
   b. The salary and benefit enhancement rate shall be added to the personal care and room and board rates otherwise established under this chapter for the rate years beginning July 1, 2009, and July 1, 2010. The enhancement rate may not be effective before the implementation date of the enhancement by the facility.
   c. For the rate year beginning July 1, 2010, the salary and benefit enhancement rate effective July 1, 2009, shall be reduced by one-twelfth for each month the costs related to the implementation of the enhancement are included in the cost report used to establish the facility's July 1, 2010, rate and then increased by the adjustment factor set forth in section 75-02-07.1-21.
   d. Any additional funds provided must be used to provide salary and benefit enhancements 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 section 75-02-07.1-23.

4. The department shall increase rates otherwise established by this chapter for supplemental payments or one-time adjustments to historical costs approved by the legislative assembly.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; July 1, 2009; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

north dakota
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Jack Dalrymple, Governor
Carol K. Olson, Executive Director

May 12, 2011

RE: Proposed Amendments to N.D. Admin. Code Chapter 75-02-07.1
Ratesetting for Basic Care

TO WHOM IT MAY CONCERN:

The Department of Human Services is proposing amendments to N.D. Admin. Code chapter 75-02-07.1, Ratesetting for Basic Care. The department has adopted procedures to assure public input into the formulation of such rules prior to adoption.

In conformity with those procedures, we are providing you with a copy of the proposed rules and are requesting that you provide any written data, views, or arguments no later than 5:00 p.m. on Monday, June 27, 2011.

The department has scheduled an oral hearing on Thursday, June 16, 2011. Further information concerning the public hearing is included in the attached notice of proposed rulemaking and public hearing.

Your participation is welcomed, as are your suggestions. Please send all written data, views, or arguments to: Rules Administrator, Department of Human Services, State Capitol - Judicial Wing, 600 E. Boulevard Ave., Bismarck, ND 58505-0250.

Sincerely,

Carol K. Olson

Carol K. Olson,
Executive Director

CKO/kh

Attachments

Cc: John Walstad, Legislative Council
LeeAnn Thiel, Medical Services