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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 21-0022

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

July 19, 2022

Caprice Knapp
Director
ND Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

Re: North Dakota 21-0022

Dear Ms. Knapp:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0022. Effective for dates of services on or after January 1, 2022, this amendment updates the reimbursement methodology for nursing facility (NF) services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 21-0022 is approved effective January 1, 2022. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044 or Christine.storey@cms.hhs.gov.

Sincerely,

Rory Howe
Director

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21 — 0022

2. STATE: ND

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447, Subpart C, 42 CFR 447.252

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 14,553,037
b. FFY 2023 $ 18,665,399

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Subsection 1:
Pages i, 1, 4a, 4b, 4c, 8, 9, 11, 18, 24, 26, 27, 29, 32, 33, 37, 46, 47, 48, 52, 53, 54, 55, 56, 59, 60a, 61, and 71-79

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-D, Subsection 1:
Pages i, 1, 4a, 4b, 8, 9, 11, 18, 24, 26, 27, 29, 32, 33, 37, 46, 47, 48, 52, 53, 54, 55, 56, 59, 60a, 61 (TN 92-003, 94-001, 98-002, 00-003, 09-001, 09-011, 12-006, 15-011, 16-0004, 20-0001, 21-0001)

9. SUBJECT OF AMENDMENT

Amends the State Plan to implement a new payment methodology for Direct, Other Direct and Indirect Care Costs for Nursing Fac

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Caprice Knapp

12. TYPED NAME
Caprice Knapp

13. TITLE
Medical Services Director

14. DATE SUBMITTED
December 27, 2021

15. RETURN TO
Caprice Knapp, Director
Medical Services Division
ND Department of Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250

FOR CMS USE ONLY

16. DATE RECEIVED
December 27, 2021

17. DATE APPROVED
July 19, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

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Section 1 - 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 factor" means the Centers for Medicare and Medicaid Services skilled nursing facility market basket index four-quarter moving average percent change for quarter two of the applicable rate year from the current market basket data file publicly available as of August 31 of the year preceding the rate year. The adjustment factor shall also include any legislatively approved inflation increase for nursing facilities.

4. "Admission" means anytime a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "Chain organization" means a group of two or more health care facilities which are 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 which are engaged in other activities not directly related to health care.

7. "Community contribution" means contributions to civic organizations, and sponsorship of community activities. It does not include donations to charities.

8. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, determination of cost limitations, and determination of rates.

9. "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.

10. "Cost report" means the department approved form for reporting costs, statistical data and other relevant information of the facility.

11. "Department" means the Department of Human Services.

12. "Depreciable assets" means a capital asset for which the cost must be capitalized for rate setting purposes.

13. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

51. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing-bed facility, transitional care unit, subacute unit, an intermediate care facility for individuals with intellectual disabilities, or an acute care setting, or, if not in an institutional setting, is not receiving home and community based waivered services.

52. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

53. "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 in Section 15;

    b. A sale and leaseback to the same licensee;

    c. A transfer of an interest to a trust;

    d. Gifts or other transfers for nominal or no consideration;

    e. A merger of two or more related organizations;

    f. A change in the legal form of doing business;

    g. The addition or deletion of a partner owner or shareholder; or

    h. A sale, merger, reorganization, or any other transfer of interest between related organizations.

54. "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 located on the site used directly for resident care.

55. "Capital asset" 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.

56. "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.

57. "Noncovered day" means a resident day that is not payable by medical assistance but is counted as a resident day.

58. "Depreciation guidelines" means of the American Hospital Association's guidelines as published by American Hospital Publishing, Inc. in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2018 edition.

59. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

60. "Hospice general inpatient care" means short-term inpatient care necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. It does not mean care provided to an individual residing in a nursing facility.

61. "Institutional leave day" means any day that a resident is not in the facility, but is in another nursing facility, swing-bed facility, transitional care unit, subacute care unit, or intermediate care facility for individuals with intellectual disabilities.

62. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

63. "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.

64. "Respite care" means short-term care provided to an individual when necessary to relieve family members or other persons caring for the individual at home.

65. "Working capital debt" means debt incurred to finance nursing 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.

66. "Certified nurse aide" means an individual who has satisfactorily completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR §483.151-483.154 or who has been deemed or determined competent as provided in 42 CFR §483.151 (a) and (b); and is registered on a state-established registry of nurse aides as required by 42 CFR §483.156

67. “Rate adjustment percentage” means the percentage used to determine the minimum adjustment threshold to the rate weight of one for all facilities. The percentage is thirty-sixth hundredths of one percent effective with the June 30, 2019, cost report period.

68. “Margin cap” means a percentage of the price rate limit which represents the maximum per diem amount a facility may receive if the facility has historical operating costs, including adjustment factors, below the price rate.

69. “Peer group” means the grouping of facilities based on their licensed bed capacity available for occupancy as of June thirtieth of the report year to determine the indirect care cost category

price rate. The large peer group shall be facilities with licensed capacity greater than fifty-five beds. The small peer group shall be facilities with licensed bed capacity of fifty-five beds or less.

70. "Price rate" means the rate calculated using historical operating costs and adjustment factors up to the limit rate for the direct care, other direct care, and indirect care cost categories.

g. The department may grant a fifteen-day extension of the reporting deadline to a facility.

3. The department may perform an audit of the latest available report year of each facility at least once every six years and retain for at least three years all audit-related documents, including cost reports, working papers, and internal reports on rate calculations used and generated by audit staff in performance of audits and in the establishment of rates. Audits must meet generally accepted governmental auditing standards.

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 facility claims previously adjusted costs as allowable 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.

Section 3 - General Cost Principles

1. For rate-setting purposes, a cost must satisfy the following criteria:

    a. The cost is ordinary, necessary, and related to resident care.

    b. The cost is what a prudent and cost conscious business person would pay for the specific good or service in the open market in an arm's length transaction.

    c. The cost is for goods or services actually provided in the facility.

2. The cost effects of transactions which circumvent these rules are not allowable under the principle that the substance of the transaction prevails over form.

3. Reasonable resident-related costs will be determined in accordance with the rate setting procedures set forth in this plan, the rate setting manual, instructions issued by the department, and Principles of Reimbursement for Provider Costs (Centers for Medicare and Medicaid Services Provider Reimbursement Manual). If conflicts occur between the rate setting manual or instructions issued by the department and Centers for Medicare and Medicaid Services Provider Reimbursement Manual, the rate setting manual or instructions issued by the department will prevail.

4. Costs incurred due to management inefficiency, unnecessary care, unnecessary facilities, agreements not to compete, or activities not commonly accepted in the nursing facility industry are not allowable.

Section 5 - Exclusions

1. A facility that exclusively provides residential services for nongeriatric individuals with physical disabilities or a unit within a facility which exclusively provides geropsychiatric services shall not be included in the calculation of the rate limitations.

2. The rate for a unit within a facility which exclusively providers geropsychiatric services must be established using the actual allowable historical costs adjusted by the indices under Section 24 - Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs. Actual allowable historical costs must be determined using the applicable sections of the policies and procedures. An operating margin and incentive determined under Section 25 must be included in the facility's cost rate.

3. The direct care rate for a unit within a facility which exclusively provides geropsychiatric services must be established using the allowable historical operating costs and adjustment factors under Section 37. The margin cap for direct care must be included in the facility's direct care rate.

4. The direct care rate for a facility that exclusively provides residential services for nongeriatric individuals with physical disabilities must be established using the allowable historical operating costs and adjustment factors under Section 37. The margin cap for direct care must be included in the facility's direct care rate.

Section 10 – Property Costs

Property related costs and other pass through costs include only those costs identified in this section.

1. Depreciation.

2. Interest expense on capital debt.

3. Property taxes including special assessments as provided for in Section 20 – Taxes.

4. Lease and rental costs.

5. Start up costs.

6. Reasonable legal and related expenses:

   a. Incurred or as a result of a successful challenge to a decision by a governmental agency, made on or after January 1, 1990, regarding a rate year beginning on or after January 1, 1990.

   b. Related to legal services furnished on or after January 1, 1990; and

   c. In the case of a partially successful challenge, not in excess of an amount determined by developing a ratio of total amounts claimed successfully to total amounts claimed in the partially successful challenge and applying that ratio to the total legal and related expenses paid.

7. Allowable Bad Debts expense under Section 17.2 in the report year in which the bad debt is determined to be uncollectable with no likelihood of future recovery.

8. Education expense allowed under Section 12.36 in the report year in which it is expended.

9. Computer software and related technology costs, including cloud-based costs.

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 Section 15 – Related Organization; 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;

32. 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, refunding, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc., 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 such as 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, such as sales taxes, levied against the residents and collected and remitted by the provider.

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

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

34. 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 13;

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

36. 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 year provided:
        (1) The education was provided by an accredited academic or technical educational facility;
        (2) The allowable portion of the 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 in 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 expenses for an individual who is currently enrolled in an accredited academic or technical educational facility provided:
   (1) The expenses were for materials, books, or tuition;
   (2) The facility claims the cost of 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 individual's 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;

37. Alcohol and tobacco products;

38. Employment benefits associated with salary costs are not includable in a rate set under this plan;

39. Increased lease costs of a provider 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. At the election of the provider, the direct and indirect costs of providing therapy services to nonresidents, 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. Costs associated with or paid for the acquisition of licensed nursing facility capacity;

42. Goodwill;

43. 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. Salaries accrued at a facility's fiscal year end but not paid within seventy-five days of the cost report year end.

i. "Rentals of facility space income". Revenues received from outside sources for the use of facility space and equipment will be offset to property costs.

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

k. "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 chooses to make therapy costs non-allowable under subsection 40 of section 12.

l. "Bad Debt Recovery." Income for bad debts which have been 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 item, e.g., supplies or equipment, or amounts generated from default of contractual obligations related to education expense, must be offset 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. Medicare Part B therapy income must be offset unless the provider has elected to make therapy costs nonallowable under Section 12 – Nonallowable Costs.

3. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased.

4. Payments to a provider by its vendor will ordinarily be treated as purchase discounts, allowances, refunds, or rebates in determining allowable costs even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor. However, such payments may represent a true donation or grant. Examples include, but are not limited to, when: (1) they are made by a vendor in response to building or other fund raising campaigns in which communitywide contributions are solicited; (2) the volume or value of purchases is so nominal that no relationship to the contribution can be inferred. The provider must provide verification, satisfactory to the department, to support a claim that a payment represents a true donation.

5. Where an owner or other official of a provider directly receives from a vendor monetary payments or goods or services for the owner's or official's own personal use as a result of the provider's purchases from the vendor, the value of such payments, goods, or services constitutes a type of refund or rebate and must be applied as a reduction of the provider's costs for goods or services purchased from the vendor.

Section 16 - Compensation

1. Compensation on an annual basis for top management personnel will be limited, prior to allocation, if any, to the highest market-driven compensation of an administrator employed by a freestanding facility with licensed capacity during the previous report year at least equal to the licensed capacity of the smallest facility within the top quartile of all facilities ranked by licensed capacity, increased by the Consumer Price Index for All Urban Consumers, United States city average, all items index. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation divided by three hundred six-five times the number of calendar days the individual was employed.

2. Compensation includes, but is not limited to:

   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 for the personal use of the person.

   f. The cost of a domestic or other employee who works in the home of the person.

   g. Life and health insurance premiums paid for the person and medical services furnished at facility expense.

3. Reasonable compensation for a person with at least 5% ownership, persons on the governing board, or any person related within the third degree of kinship to top management personnel shall be considered an allowable cost if services are actually performed and required to be performed. The amount to be allowed shall be an amount determined by the department to be equal to the amount normally required to be paid for the same services if provided by a nonrelated employee. 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 compensation on an hourly basis may not exceed the amount to be determined to be the limitation in paragraph 1 of this section divided by two thousand eighty.

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

Section 17 – Bad Debts

1. Bad debts for charges incurred on or after January 1, 1990, and fees paid for the collection of those bad debts are allowable provided that:

    a. The bad debt results from nonpayment of the payment rate or part of the payment rate.

    b. The facility documents that reasonable collection efforts have been made, the debt was uncollectible, and there is no likelihood of future recovery. Reasonable collection efforts include pursuing all avenues of collection available to the facility including liens and judgments. In instances where the bad debt is owed by a person determined to have made a disqualifying transfer or assignment of property for the purpose of securing eligibility for medical assistance benefits, the facility shall document that it has made all reasonable efforts to secure payment from the transferee, including the bringing of an action for a transfer in fraud of creditors.

    c. The collection fee may not exceed industry standards for collection agencies and the amount of the bad debt.

    d. The bad debt does not result from the facility's failure to comply with Federal and State laws, State Rules, and Federal Regulations.

    e. The bad debt does not result from non payment of a private room rate in excess of the established rate, charges for special services, not included in the established rates, or charges for bed hold days not billable to the medical assistance program.

    f. The facility has an aggressive policy of avoiding bad debt expense which will limit potential bad debts. The facility must document that they will limit potential bad debts. The facility must document that they have taken action to limit bad debts for individuals who refuse to make payment. In no instances may allowable bad debt expense exceed 180 days of resident care per year or an aggregate of three-hundred-sixty-days (360 days) of resident care for any one individual.

2. Finance charges on bad debts which are allowed in subsection 1 are allowable if the finance charges have been offset as interest income.

7. An adjustment may not be allowed for any depreciable cost that exceeded the basis in effect for rate periods prior to January 1, 1996.

8. A per bed cost limitation based on single and double occupancy must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation or remodeling.

    a. The per bed limitation basis for double occupancy effective July 1, 2019 is $253,297.

    b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by 1.5.

    c. The double and single occupancy per bed limitation must be adjusted annually on July 1 using the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May 31.

    d. The per bed limitation 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 limitation.

    f. The per bed limitation is not applicable to projects started or approved by the state health council before July 1, 1994.

Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs

1. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.
2. For the rate year beginning January 1, 2020 the adjustment factor is 2 percent.
3. For the rate year beginning January 1, 2021 the adjustment factor is 2.5 percent.
4. For the rate year beginning January 1, 2022, the adjustment factor is 4.5 percent.

Section 25 - Rate Limits and Incentives

1. Limits - All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in Section 5 - Exclusions 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, 2021. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

    a. The limit rate for each of the cost categories will be established as follows:

        (1) Historical costs for the report year ended June 30, 2021, 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 rates effective January 1, 2022, the limit rate for each cost category is:

            (a) For the Direct Care cost category, $244.21;
            (b) For the Other Direct Care cost category, $35.03; and
            (c) For the Indirect Care cost category for the large peer group, $96.22.
            (d) For the Indirect Care cost category for the small per group, $98.78.

    b. A facility which has an actual rate that exceeds the limit rate for a cost category will receive the limit rate.

    c. The cost rate for the January 1, 2023 rate year must be the previous rate year's cost rate increased by the adjustment factor.

2. The department will review, on an ongoing basis, aggregate payments to nursing 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 nursing 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.

3. The department shall accumulate and analyze statistics on costs incurred by the nursing facilities. These statistics may be used to establish reasonable ceiling limitations taking into consideration relevant factors including resident needs, nursing hours necessary to meet resident needs, size of the nursing facility and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing facility.

4. The department shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs. The limit rates shall be the median rate plus 20 percent for the direct care cost category; the median rate plus 20 percent for the other direct care category; and the median rate plus 10 percent for the indirect care cost category. Until a new base period is established, the department shall adjust the limits annually by the adjustment factor set forth in Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs and the limit rate for those rate years may not fall below the median rate for the cost category of the applicable cost report year.

5. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to 70% times the difference between the actual rate, exclusive of an adjustment factor, and the limit rate, in effect at the end of the year immediately preceding the rate year, up to a maximum of $2.60, or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs, whichever is less will be included as part of the indirect care cost rate.

6. For rates effective through December 31, 2023, a facility will receive an operating margin of 4.40% based on the lesser of the actual direct care and other direct care rates, exclusive of an adjustment factor or the limit rate in effect at the end of the year immediately preceding the rate year. The operating margin must be added to the rate for the direct dare and other direct care cost categories of the cost rate.

Section 28 – Special Rates

1. For a new facility, the department shall establish a 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 rate must be in effect for no less than 10 months and no more than 18 months. 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 95 percent of licensed beds.

    a. If the effective date of the rate is on or after January 1 and on or before June 30, the rate must be effective for the remainder of that rate year and must continue through June 30 of the subsequent rate year. The facility shall file an interim cost report for the period ending December 31 of the year in which the facility first provides services. The cost report is due March 1 and is used to establish the actual rate effective July 1 of the subsequent rate year. The partial year rates established based on the cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up.

    b. If the effective date of the rate is on or after July 1 and on or before December 31, the 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 30 of the subsequent rate year. This cost report must be used to establish the rates for the next subsequent rate year. The facility shall file, by March 1, a cost report for the period July 1 through December 31 of the subsequent rate year.

c. The final rates for direct care, other direct care and indirect care will be limited to the lesser of the limit rates for the current rate year or the actual rates.

2. For a facility with renovations or replacements in excess of $100,000, and without a significant capacity increase, the rates 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.

3. 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. A projected property rate must be established based on projected property costs and projected census. The projected 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 property rate for the subsequent rate year must be based on projected property costs and census imputed as 95 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 95 percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

4. For a facility with no significant capacity increase and no renovations or replacements in excess of $100,000, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

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

   a. 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:

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

      (2) For a facility with less than six 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 Section 24; or

      (3) By establishing a rate based on the previous owner's cost report, if the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the rate year.

   b. Unless a facility elects to have a property rate established under paragraph c, 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:

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

      (2) For a facility with less than six months of operation under the new ownership during the report year:

Section 29 – One Time Adjustments

1. Adjustments to Meet Certification Standards

   a. The department will 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.

      (1) 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 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.

      (2) 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.

   b. 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 Section 26 – Rate Adjustments.

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 must be beyond the control of those responsible for the management of the facility.

b. The facility must submit a written request containing the following information to the Medical Services Division within sixty days after first incurring the unforeseeable expense:

   (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 facility; and

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

Section 30 - Notification of Rates

1. The department will notify each facility of the desk audit rate on or before November 24 of the year preceding the rate year, except a facility that has requested and received a cost reporting deadline extension of 15 days or less shall be notified on or before November 30 of the year preceding the rate year, and a facility that has requested and received a cost reporting deadline extension in excess of fifteen days shall be notified on or before December 15 of the year preceding the rate year.

2. The department shall notify each facility of the cost rate and the price rate for the 2022 and 2023 rate years.

3. The facility shall notify the department on or before November 29, 2021, if the facility accepts the cost rate as the established rate for the 2022 rate year.

4. The facility shall notify the department on or before November 28, 2022, if the facility accepts the cost rate as the established rate for the 2023 rate year. The facility does not have the option to choose the cost rate for the 2023 rate year if the facility's 2022 rate was the price rate.

5. The facility shall provide to all private-pay residents a thirty-day written notification of any increase in the rates for each classification. An increase in rates is not effective unless the facility has notified the private-pay residents. A facility may make a rate change without giving a thirty day written notice when the purpose of the rate change is to reflect a necessary change in the case-mix classification of a resident.

6. If the department fails to notify the facility of the desk rate by November 24 of the year preceding the rate year, the time required for giving written notice as provided for in subsection 5 must be decreased by the number of days by which the department was late in setting the rate.

(3) A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item.

(4) The authority in statute or rule upon which the appealing party relies for each disputed item.

(5) The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

b. Upon assignment, the hearing officer shall set and conduct the hearing within one hundred twenty days of the date of assignment.

c. Within sixty days after all evidence has been received, the department shall make its findings of fact and conclusions of law and enter a decision based upon its findings and conclusions.

d. A nursing home may seek a writ of mandamus to compel the hearing officer to timely set and conduct a hearing or to compel the department to timely issue a decision; however, no writ may be granted to a nursing home contributing to the delay.

Section 32 – Classifications

1. A facility shall complete a resident assessment for any resident occupying a licensed facility bed, except a respite care, hospice inpatient respite care, or hospice general inpatient care resident.

2. A resident must be classified in one of forty-eight classifications based on the resident assessment. If a resident assessment is not performed in accordance with subsection 3, except for a respite care, hospice inpatient respite care, or hospice general inpatient care resident, the resident must be included in group AAA, not classified, until the next required resident assessment is performed in accordance with subsection 3. For purposes of determining standardized resident days, any resident day classified as group AAA must be assigned the relative weight of one. A resident, except for a respite care hospice inpatient respite care or hospice general inpatient care resident, who has not been classified, must be billed at the group AAA established rate. The case-mix weight for establishing the rate for is .45. Days for respite care, hospice inpatient respite care, or hospice general inpatient care resident who is not classified must be given a weight of one when determining standardized resident days. Therapeutic, hospital, or institutional leave days that are resident days must be given a weight of .45 when determining standardized resident days.

3. Resident assessments must be completed as follows:

    a. The facility shall assess the resident within the first fourteen days after any admission or return from an acute hospital stay. The day of admission or return is counted as day one. The assessment reference date must be between day seven and day fourteen.

    b. The facility shall assess the resident quarterly after any admission or return from an acute hospital stay. The quarterly assessment period ends on the day of the third subsequent month corresponding to the day of admission or return from an acute hospital stay, except if that month does not have a corresponding date, the quarterly assessment period ends on the first day of the next month. The assessment reference period begins seven days prior to the ending date of a quarterly assessment period. The assessment reference date (A2300) on the MDS must be within the assessment reference period.

    c. An assessment must be submitted upon initiation of rehabilitation therapy if initiation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in subdivision b.

Section 37 - Rate Determination for Price

1. For each cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 3 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 shall include the margin cap. The actual rate as calculated is compared to the price rate for each cost category, excluding property, to determine the lesser of the actual rate or the price 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 Section 32 - Classifications to establish the direct care rate for that classification. The lesser of the actual rate or the price rate for other direct care and indirect care, property costs and the adjustments provided for in subsection 2 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. 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 price rate for the direct care and other direct care cost categories. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

   d. All facilities must be grouped into peer groups based on the licensed bed capacity available for occupancy as of June thirtieth of the report year. Facilities in each peer group must be used to establish a price rate for the indirect care cost category for that peer group. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

   e. The price rate for each of the cost categories must be established using historical operating costs for the base year. The price rate will be established using the same

percentage of the median used to establish the limit rates for the January 1, 2021, rate year.

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

g. The price rate for each of the cost categories for the January 1, 2023, rate year shall be the price rate for the previous rate year increased by the adjustment factor.

h. The price rate for each of the cost categories for the January 1, 2025, rate year shall be the price rate for the previous rate year increased by the adjustment factor.

i. 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.

j. The department may waive or reduce the application of subdivision i 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 i.

k. The department may waive the application of subdivision i 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.

3. An adjustment factor shall be used for purposes of adjusting historical operating costs for direct care, other direct care, and indirect care under subsection 1 and for purposes of adjusting the price rate for direct care costs, other direct care costs, and indirect care costs under subsection 2, but may not be used to adjust property costs under either subsection 1 or 2.

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

(4) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least the rate adjustment percentage per day.

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 the rate adjustment percentage per day that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

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

(4) 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 the rate adjustment percentage per day 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 the rate adjustment percentage per day had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) 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.

5. 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. 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.

c. 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.

6. 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, and indirect care 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 six 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 six 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 six 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 six 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 a rate equal to the price rate 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. 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 rate is on or after January first and on or before June thirtieth, the 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 a cost report for the period ending December thirty-first of the year in which the facility first provides services. The cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate established based on this cost report must include applicable margins and adjustment factors and may not be subject to any cost settle-up.

(2) If the effective date of the rate is on or after July first and on or before December thirty-first, the 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.

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, and indirect care 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, and indirect care based on the last report year, must be applied to all licensed beds. A projected property rate must be established based on projected property costs and projected census. The projected 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 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.

7. 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 price 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 4.

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 price 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 4.

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 use of margin cap.

(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 margin cap, 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 margin cap 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 price 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 4.

(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.

e. Adjustments for a significant reduction in census

(1) A facility may request a revised desk rate if the facility has a significant reduction in census. The reduction in census cannot be due to renovation.

(2) For purposes of this section a significant reduction in census is defined as:

(a) At least ten percent of licensed bed capacity for a facility in the large peer group; and

(b) At least five percent of licensed bed capacity for a facility in the small peer group.

(3) The licensed bed capacity will be based on the licensed beds used to establish the peer groups.

(4) The revised desk rate shall be calculated using:

(a) The facility's allowable historical operating costs from the most recent base year increased by the adjustment factors, if any, up to the current report year.

(b) The facility's allowable property costs from the most recent report year.

(c) The standardized resident days and resident days from the most recent report year.

(d) The revised desk rate shall be limited to the price rate for direct care, other direct, and indirect cost categories.

(5) A facility that receives a revised desk rate under this section shall not increase licensed bed capacity during the rate year.