

RATE SETTING MANUAL
FOR
NURSING FACILITIES



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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” mean the inflation rate for nursing home 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. “Allowable cost” means the facility’s actual cost after appropriate adjustments as required by medical assistance regulations.
6. “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 3 of 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. The sale, merger, reorganization, or any other transfer of interest between related organizations.
7. "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.
8. "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.
9. “Certified nurse aide” means:
 - a. 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 through 483.154 and is registered on a state-established registry of nurse

- aides as required by 42 CFR 483.156; 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; or
- b. An individual, who has worked less than four months as a nurse aide, enrolled in a training and evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154.
10. "Chain organization" means a group of two or more 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 health care.
11. "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.
12. "Community contribution" means contributions to civic organizations, and sponsorship of community activities. It does not include donations to charities.
13. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, determination of cost limitations, and determination of rates.
14. "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 divided for purposes of cost assignment and allocations.
15. "Cost report" means the department approved form for reporting costs, statistical data and other relevant information of the facility.
16. "Date of acquisition" means the date when ownership of a depreciable asset transfers from the transferor to the transferee such that both are bound by the transaction. For purposes of transfers of real property, the date of acquisition is the date of delivery of the instrument transferring ownership. For purposes of titled personal property, the date of acquisition is the date the transferee receives a title acceptable for registration. For purposes of all other capital assets, the date of acquisition is the date the transferee possesses both the asset and an instrument, describing the asset, which conveys the property to the transferee.
17. "Department" means the Department of Human Services.
18. "Depreciable Asset" means a capital asset for which the cost must be capitalized for rate setting purposes.
19. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.
20. "Depreciation guidelines" means the American Hospital Association's guidelines as published by American Hospital Publishing, Inc. in "Estimated Useful Lives of Depreciable Hospital Assets", Revised 2013 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 nursing and therapy 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 nursing facility premises.
25. "Employment benefits" means fringe benefits, other employee benefits including vision insurance, disability insurance, long term-care insurance, employee assistance programs, employee child care benefits and payroll taxes.
26. "Established rate" means the rate paid for services.
27. "Facility" means a nursing facility not owned or administered by state government or a nursing facility owned or administered by state government which agrees to accept a rate established under this chapter. It does not mean an intermediate care facility for individuals with intellectual disabilities.
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 decision rate" means the amount, if any, determined on a per-day basis, by which a rate otherwise set under this chapter is increased as a result of a request for reconsideration, a request for administrative appeal, or a request for judicial appeal taken from a decision on an administrative appeal.
30. "Final rate" means the rate established after any adjustments by the department, including, but not limited to, adjustments resulting from cost report reviews and audits.
31. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.
32. "Freestanding facility" means a nursing facility that does not share basic services with a hospital-based provider.
33. "Fringe benefits" means worker's compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, uniform allowances, and medical services furnished at nursing 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. "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.

37. "Hospice inpatient respite care" means short-term inpatient care provided to an individual when necessary to relieve family members or other persons caring for the individual at home. Care may be provided for no more than five consecutive days. For purposes of the definition, home does not include a nursing facility.
38. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient or has been identified in a resident assessment instrument as "discharged anticipated to return".
39. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy and dietary, exclusive of food costs.
40. "In-house resident day" for basic care and nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic, institutional or hospital leave. "In-house resident day" for hospitals means an inpatient day.
41. "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, sub-acute care unit, or intermediate care facility for individuals with intellectual disabilities.
42. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.
43. "Limit rate" means the rate established as the maximum allowable rate for a cost category.
44. "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.
45. "Managed care organization" means a medicaid managed care organization as that term is defined in section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)].
46. "Medical assistance program" means the program that pays the cost of health care provided to eligible recipients pursuant to NDCC Chapter 50-24.1.
47. "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.
48. "Medicare part B income" means the interim payment made by Medicare during the report year plus any cost settlement payments made to the provider or due from the provider for previous periods which are made during the report year and which have not been reported to the department prior to June 30, 1997.
49. "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.

50. "Non-covered day" means a resident day that is not payable by medical assistance but is counted as a resident day.
51. "Other direct care costs" means the cost category for allowable activities, social services, laundry and food costs.
52. "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.
53. "Pending decision rate" means the amount, determined on a per-day basis, by which a rate otherwise set under this chapter would increase if a facility prevails on a request for reconsideration, on a request for an administrative appeal, or on a request for a judicial appeal taken from a decision on an administrative appeal; however, the amount may not cause any component of the rate to exceed rate limits established under this chapter.
54. "Private-pay resident" means a nursing facility resident on whose behalf the facility is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with rate setting authority including Veteran's Administration or Medicare, or whose payment is not negotiated by any managed care organization contracting with a facility to provide services to the resident.
55. "Private room" means a room equipped for use by only one resident.
56. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.
57. "Provider" means the organization or individual who has executed a provider agreement with the department.
58. "Rate year" means the calendar year from January 1 through December 31.
59. "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 and federal 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.
60. "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 where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.
61. "Report year" means the fiscal year from July 1 through June 30 for the year immediately preceding the rate year.
62. "Resident" means a person who has been admitted to the facility, but not discharged.
63. "Resident day" in a nursing facility means any day for which service is provided or for which payment is ordinarily sought, including hospital 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.

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. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting and setting.
66. "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 that reduces the number of its licensed beds and thereafter relicenses those beds. It does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.
67. "Standardized resident day" means a resident day times the classification weight for the resident.
68. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing bed facility, transitional care unit, sub-acute 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 waived services.
69. "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.
70. "Working capital debt" means debt incurred to finance nursing facility operating costs, but does not include debt incurred to acquire a capital asset or to refund or refinance debt associated with acquiring a capital asset.

Section 2 – Financial Reporting Requirements

1. Records.
 - a. The facility shall maintain on the premises the required census records and financial information in a manner sufficient to provide for a proper audit or review. For any cost being claimed on the cost report, sufficient data must be available as of the audit date to fully support the report item.
 - b. Where several facilities are associated with a group and their accounting and reports are centrally prepared, added information must be submitted, for those items known to be lacking support at the reporting facility, with the cost report or must be provided to the local facility prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost. Home office cost reporting and cost allocation must be in conformance with applicable sections in this manual and The Provider Reimbursement Manual paragraphs 2150 and 2153.
 - c. Each provider shall maintain, for a period of not less than five years following the date of submission of the cost report to the department, accurate financial and

statistical records of the period covered by such cost report in sufficient detail to substantiate the cost data reported. Each provider shall make such records available upon reasonable demand to representatives of the department or to the secretary of health and human services or representatives of the secretary.

- d. Except for motor vehicles used exclusively for resident-related activities, the provider shall maintain a mileage log for all motor vehicles that identifies mileage and purpose of each trip. Vehicle mileage for nonresident-related activities must be documented.

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 year-end and when subsequently reported. Rate setting procedures must prevail if conflicts occur between rate setting 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 October first of each year, each facility shall provide to the department:
 - (1) A cost report for the report year ended June 30 on forms prescribed by the department.
 - (2) Except for state-owned facilities, a copy of an audited report of the facility's financial records from an independent certified public accountant that must include an audited statement of the rates charged to private pay residents. The examination must be conducted in accordance with generally accepted auditing standards. For provider organizations that operate more than one nursing facility, a consolidated audit report may be provided. The information must be reconciled to each facility's cost report.
 - (3) A complete statement of fees and charges for private-pay residents for the report year.
 - (4) A statement of ownership for the facility, including the name, address, and proportion of ownership of each owner.
 - (a) If a privately held or close 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 shall be identified regardless of the proportion of ownership interest.

- (b) If a publicly held corporation has an ownership interest of 15 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.
- (5) 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 the document remains unchanged since the most recent statement given pursuant to this subsection.
- (6) Supplemental information reconciling the costs on the financial statements with costs on the cost report.
- (7) The following information upon request by the department:
 - (a) Access to certified public accountant's audit work papers that support the audited 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) Audited financial statements for any organization, excluding individual nursing 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 reconciles costs on the financial statements to costs for the report year.
 - (d) Audited financial statements for every 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 reconciles costs on the financial statements to costs for the report year.
- d. In the event 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 rate in effect on October first. Reinstatement of the rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.
- e. The 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.
- f. Costs reported must include total costs and be adjusted to allowable costs.
- g. Adjustments required by the Provider Audit Unit, to attain allowable cost, though not meeting the Medicaid state agency or the state Medicaid investigative group

criteria of fraud or abuse on their initial identification, may, if repeated on future cost filings, be considered as possible fraud and abuse. The Provider Audit Unit may forward all such items identified to the appropriate Medicaid investigative group.

- h. The department may grant an extension of the reporting deadline to a facility for good cause.
- 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:
 - a. Be ordinary, necessary, and related to resident care;
 - b. Be what a prudent and cost conscious business person would pay for the specific good or services in the open market in an arm's length transaction; and
 - c. Be for goods or services actually provided in the facility.
- 2. The cost effects of transactions that circumvent these rules are not allowable under the principle that the substance of the transaction prevails over form.

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

Section 4 – Participation Requirement

A facility must comply with the following provisions in order to be eligible to receive medical assistance payments:

1. A facility may not charge private-pay residents rates that exceed those rates approved by the department for medical assistance recipients except that:
 - a. A facility may charge a higher rate for a private room.
 - b. A facility may charge for special services not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services. Special services must be available to all residents and residents must be free to select or decline the special services. Special services may not include services provided by the facility in order to comply with licensure or certification standards that, if not provided, would result in a deficiency or violation by the facility. Services beyond those required to comply with licensure or certification standards may not be charged separately as special services if the services were included as allowable costs used to establish the current established rate. Special services may include cable TV, telephones, long distance calls, nonroutine hair care requested by a resident, such as permanents, and the additional cost of brand name supplies requested by a resident and not ordinarily stocked. A facility shall inform the resident or a person acting on behalf of the resident that a charge may be made and the amount of the charge at the time a request for the special services is made.
 - c. A facility may charge to hold a bed for a period in excess of the periods covered by subsections 3, 4, 5 and 6 of section 6 if:
 - (1) The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge;
 - (2) For a medical assistance resident, the payment comes from sources other than from the resident's monthly income; and
 - (3) All residents are charged the same amount.
 - d. A facility may charge for Medicare Part A and B coinsurance and deductibles.

- e. A facility that charges a private-pay resident a rate in violation of N.D.C.C. 50-24.4 is subject to action for civil damages. The damages awarded may include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent.
2. A facility may not require, as a condition of admission, any applicant to pay a fee or a deposit, loan any money to the facility, or promise to leave all or part of the applicant's estate to the facility.
3. A facility may not require any resident to use a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.
4. A facility may not provide differential treatment on the basis of status with regard to public assistance.
5. A facility may not discriminate in admission, services offered, or room assignment on the basis of status with regard to medical assistance. The collection and use by a facility of financial information of any applicant pursuant to a preadmission screening program does not raise an inference that the facility is using that information for any purpose prohibited by N.D.C.C. 50-24.1. Admission discrimination includes:
 - a. Basing admission decisions upon an assurance by the applicant to the facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek medical assistance for payment of facility care costs; or
 - b. Engaging in preferential selection from waiting lists based on an applicant's ability to pay privately.
6. A facility may not require any vendor of medical care, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of the fee to the facility except as payment for the fair market value of renting or leasing space or equipment of the facility or purchasing support services, if those agreements are disclosed to the department.
7. A facility may not refuse, for more than twenty-four hours, to accept a resident returning to the same bed or an available bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.
8. A facility may not violate any rights of a health care facility resident as set forth in NDCC section 50-10.2-02 Resident Rights.
9. Any facility certified as a nursing facility shall participate in Medicare part A and part B with respect to at least thirty percent of the beds in the facility.
10. If Medicare covered services are provided to a resident who is simultaneously eligible for medical assistance and Medicare, the facility shall bill for Medicare part A and B before billing Medical Assistance, and may not bill Medical Assistance if the resident (or someone acting on the resident's behalf) has refused or waived use of available Medicare benefits. The department may be billed only for charges not payable by Medicare. Medicare Part B covered services are not included in the daily rate.
11. A facility shall file on behalf of each resident or assist each resident in filing requests for any third-party benefits to which the resident may be entitled.

12. A facility shall be certified to participate in the medical assistance program and have a provider agreement with the department.
13. If a facility does not comply with provisions of this section, the department may continue, if extreme hardship to the residents would otherwise result, to make medical assistance payments to the facility for a period not to exceed one hundred eighty days from the date of mailing a formal notice. In these cases, the department shall issue an order requiring the facility to correct the violation. The nursing home has twenty days from its receipt of the order to correct the violation. If the violation is not corrected within the twenty day period, the department may reduce the payment rate to the facility by up to twenty percent. The amount of the payment rate reduction must be related to the severity of the violation, and must remain in effect until the violation is corrected. The facility may seek reconsideration of or appeal the department's action as provided for in Section 31 - Reconsiderations and Appeals.
14. A facility may charge a higher rate for a private room used by a medical assistance resident if:
 - a. The private room is not medically necessary;
 - b. The resident, or a person acting on behalf of the resident, has requested the private room and the facility informs the person making the request, at the time of the request, of the amount of the payment and that the payment must come from sources other than a resident's monthly income; and
 - c. The payment does not exceed the amount charged to private-pay residents.
15. A facility may not accept any payment to hold a bed prior to the admission of a resident.
16. A facility shall readmit a resident whose leave exceeds the facility's bed hold period upon the first availability of a bed in a semi-private room if the resident:
 - a. Requires the services provided by the facility; and
 - b. Is eligible for medical assistance.
17. A facility may not charge a managed care organization a rate that is less than the rate approved by the department for a Medical Assistance recipient in the same classification.

Section 5 – Exclusions

1. A facility that exclusively provides residential services for nongeriatric individuals with physical disabilities or a unit within a facility that exclusively provides geropsychiatric services shall not be included in the calculation of the rate limitations and its rate must not be limited by such limitations. The facility rate or the rate for a unit within a facility which exclusively provides 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-Rate Limits and Incentives must be included in the facility rate.

2. A facility may establish a rate for respite care, hospice inpatient respite care, or hospice general inpatient care services.

Section 6 – Resident Days

1. A resident day is any day for which service is provided or for which payment is ordinarily sought for use of a bed. The amount of remuneration has no bearing on whether a day should be counted.
2. Adequate census records must be prepared and maintained on a daily basis by the facility to allow for proper audit of the census data. The daily census records must include:
 - a. Identification of the resident;
 - b. Entries for all days and not just by exception;
 - c. Identification of type of day, i.e., hospital, in-house;
 - d. Identification of the resident's classification; and
 - e. Monthly totals by resident, by classifications for all residents, and by type of day.
3. A maximum of fifteen days per occurrence may be allowed for payment by the medical assistance program for hospital leave. The payment rate for allowed hospital leave days may not exceed the established rate for group PA1 under the reduced physical functioning category. Hospital days in excess of fifteen consecutive days not billable to the medical assistance program are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 4.
4. A maximum of twenty-four therapeutic leave days per individual per rate year may be allowed for payment by the medical assistance program. The payment rate for allowed therapeutic leave days may not exceed the established rate for group PA1 under the reduced physical functioning category. Therapeutic leave days in excess of twenty-four per year are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 4.
5. Institutional leave days are not billable to the department and are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 4.
6. Hospital and therapeutic leave days, occurring immediately following a period when a resident was receiving Medicare Part A benefits in the facility, are not billable to the department and are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 4.
7. Residents admitted to the facility through a hospice program or electing hospice benefits while in a facility must be identified as hospice residents for census and billing purposes.

Section 7 – Direct Care Costs

Direct care costs include only those costs identified in this section.

1. Therapies:
 - a. Salary and employment benefits for speech, occupational, and physical therapists or for personnel, who are not reported in subsection 2, performing therapy under the direction of a licensed therapist.
 - b. The cost of non-capitalized therapy equipment or supplies used to directly provide therapy.
 - c. Training required to maintain licensure, certification or professional standards and the related travel costs.
2. Nursing:
 - a. Salary and employment benefits for the director of nursing, nursing supervisors, inservice trainers for nursing staff, registered nurses, licensed practical nurses, quality assurance personnel, certified nurse aides, individuals providing assistance with activities of daily living identified in subdivision a of subsection 5 of section 32, individuals with a cognitive impairment who provide care-related services and who require the direction or supervision of a registered nurse in order to perform those services, and ward clerks.
 - b. Routine nursing care supplies including items furnished routinely and relatively uniformly to all residents; 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. (See Appendix A)
 - c. Training required to maintain licensure, certification or professional standards requirements and the related travel costs.
 - d. Routine hair care.
 - e. The cost of noncapitalized wheelchairs.

Section 8 – Other Direct Care Costs

Other direct care costs include only those costs identified in this section.

1. The cost of consumable food products.
2. Dietary supplements, including supplements used for tube feedings such as elemental high nitrogen diet.

3. Laundry costs:
 - 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.
4. Social service costs - Salary and employment benefits or consultant fees for social workers or social worker designees.
5. Activities costs:
 - a. Salary and employment benefits for activities director and activities aides.
 - b. The cost of leisure and recreational activities and supplies including games, ceramics, pets, out-of-house activities, and non-capitalized exercise equipment.

Section 9 – Indirect Care Costs

Indirect care costs include all costs specifically identified in this section. Indirect care costs must be included in total, without direct or indirect allocation to other cost categories unless specifically provided for elsewhere.

1. Administration - Direct costs for administering the overall activities of the facility include:
 - a. Salary and employment benefits for administrators, except in a facility of sixty or fewer beds, part of an administrator's salary may be allocated to other cost categories provided adequate records identifying the hours and services provided are maintained by the facility.
 - b. Salary and employment benefits for assistant administrators, top management personnel, accounting personnel, clerical personnel, secretaries and receptionists, data processing personnel, purchasing, receiving and store personnel, medical director, and salary and employment benefits of all personnel not designated in other cost categories.
 - c. Board of directors' fees and related travel expenses.
 - d. Security personnel or services.
 - e. Supplies except as specifically provided for in the Direct Care, Other Direct Care, and other cost centers of the Indirect Care cost category.
 - f. Insurance, except insurance included as a fringe benefit and insurance included as part of related party lease costs.
 - g. Telephone and telegraph.

- h. Postage and freight.
 - i. Membership dues and subscriptions.
 - j. Professional fees for services such as legal, accounting and data processing.
 - k. Central or home office costs including property costs except as provided for in Section 14 - Home Office Costs.
 - l. Advertising and personnel recruitment costs.
 - m. Management consultants and fees.
 - n. Bad debts and collection fees as provided for in Section 17 - Bad Debts.
 - o. Business meetings, conventions, association meetings and seminars.
 - p. Travel, except as necessary for training programs for personnel required to maintain licensure, certification, or professional standards requirements.
 - q. Training, except for training for personnel required to maintain licensure, certification or professional standards requirements.
 - r. Business office functions.
 - s. Computer software costs, except costs that must be capitalized, and computer maintenance contracts.
 - t. Working capital interest.
 - u. Any costs that cannot be specifically classified to other cost categories.
2. Chaplain:
- a. Salary and employment benefits for all personnel assigned to meet the spiritual needs of the residents.
 - b. Supplies and other expenses related to meeting the spiritual needs of the residents.
3. Pharmacy - Compensation for pharmacy consultants.
4. Plant operations:
- a. Salary and employment benefits for a director of plant operations, engineers, carpenters, electricians, plumbers, caretakers, vehicle drivers, and all other personnel performing tasks related to maintenance or general plant operations.
 - b. The cost of heating and cooling, electricity, water, sewer and garbage and cable television.
 - c. Repairs and maintenance contracts and purchased services.

- d. Supplies necessary for repairs and maintenance of the facility, including hardware, building materials and tools, other maintenance related supplies and non-capitalized equipment not included elsewhere.
 - e. Motor vehicle operating and resident transportation expenses.
5. Housekeeping:
- a. Salary and employment benefits for a director of housekeeping, housekeepers and other cleaning or housekeeping personnel.
 - b. Cost of cleaning supplies including soaps, waxes, polishes, household paper products such as hand towels and toilet paper, and non-capitalized cleaning equipment.
 - c. Contracted services for housekeeping.
6. Dietary:
- a. Salary and employment benefits for a director of dietary, nutritionists, dieticians, cooks, and kitchen personnel involved in the preparation and delivery of food.
 - b. The cost of dietary supplies and utensils including dietary paper products, silverware, and noncapitalized kitchen and dining equipment.
7. Medical Records - Salary and employment benefits for personnel performing medical records maintenance.

Section 10 – Property Costs and Other Passthrough 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;
 - b. Related to legal services 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 in the report year in which bad debt is determined to be uncollectible with no likelihood of future recovery.
- 8. Education expense allowed under section 12 in the report year in which it is expended.

Section 11 – 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 a hospital or has more than one license (including basic care), the following allocation methods must be used:
 - (1) Nursing 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, nursing salaries must be allocated based on revenues for resident services.
 - (2) Salaries for a Director of Nursing or nursing supervisors that cannot be reported based on actual costs or time studies must be allocated based on nursing salaries or full-time equivalents of nursing staff.
 - (3) Salaries for cost center supervisors must be allocated based on cost center salaries or full-time equivalents of supervised staff.
 - (4) Staff development or inservice trainer salaries must be allocated to nursing and therapies based on the ratio of nursing and therapy salaries to total salaries, to non-long term care based on the ratio of non-long term care salaries to total salaries, and to administration based on the ratio of total salaries less nursing salaries, therapy salaries, and non-long term care salaries to total salaries.
 - (5) Other nursing costs must be allocated based on resident days.
 - (6) Therapy costs, other than therapy salaries and purchased services, must be allocated based on the ratio of therapy salaries and purchased services in the nursing facility to total therapy salaries and purchased services.

- (7) Dietary and food costs must be allocated based on the number of meals served or in-house resident days.
 - (8) Laundry costs must be allocated on the basis of pounds of laundry or in-house resident days.
 - (9) Activity costs must be allocated based on in-house resident days.
 - (10) Social service costs must be allocated based on resident days.
 - (11) Housekeeping costs must be allocated based on weighted square footage.
 - (12) Plant operation costs must be allocated based on weighted square footage.
 - (13) Medical records costs must be allocated based on the number of admissions or discharges and deaths.
 - (14) Pharmacy costs for consultants must be allocated based on in-house resident days.
 - (15) Administration costs must be allocated on the basis of the percentage of total adjusted costs, excluding property, administration, chaplain, and utility costs, in each facility.
 - (16) 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.
 - (17) Chaplain costs must be allocated based on the percentage of total adjusted costs, excluding property, administration, chaplain, and utility costs.
 - (18) 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 Medical Services Division. 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 must be included as non-long term care costs.
 - e. For purposes of this section, "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 section for that cost category.

2. If a facility cannot directly identify salaries and employment benefits to a cost category, the following cost allocation methods must be used:
 - a. Salaries, excluding staff development and inservice trainer salaries, must be allocated using time studies. Time studies must be conducted 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 reporting year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, salaries must be allocated entirely to the Indirect Care Costs if any of the employee's job duties are included in this cost category. Otherwise, salaries must be Other Direct Care costs.
 - b. Staff development and inservice trainer salaries must be allocated to nursing and therapies based on the ratio of nursing and therapy salaries to total salaries and to administration based on the ratio of total salaries less nursing and therapy salaries to total salaries.
 - c. Employment benefits must be allocated based on the ratio of salaries in the cost category to total salaries.
3. A facility that operates or is associated with nonresident-related activities, such as apartment complexes, shall allocate all costs, except administration costs, in the manner required by Subsection 1, and shall allocate administration costs as follows:
 - a. If total costs of all nonresident-related activities, exclusive of property, administration, chaplain, and utility costs, exceed five percent of total facility costs, exclusive of property, administration, chaplain, and utility costs, administration costs must be allocated on the basis of the percentage of total cost, excluding property, administration, chaplain, and utility costs.
 - b. If total costs of all nonresident-related activities, exclusive of property, administration, chaplain, and utility costs, are less than five percent of total facility costs, exclusive of property, administration, chaplain, and utility costs, administration costs must be allocated to each activity based on the percent gross revenues for the activity is of total gross revenues, except the allocation may not be based on a percentage exceeding two percent for each activity.
 - c. If the provider can document, to the satisfaction of the department, that none of the facility resources or services are used in connection with the nonresident-related activities, no allocation need be made.
 - d. The provisions of this subsection do not apply to the activities of hospital and basic care facilities associated with a facility.
4. All costs associated with a vehicle not exclusively used by a facility must be allocated between resident-related and nonresident-related activities based on usage logs.

Section 12 – Nonallowable Costs

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

1. Political contributions;
2. Salaries or expenses of a lobbyist;
3. Advertising designed to encourage potential residents to select a particular facility;
4. Fines or penalties, including interest charges on the penalty, bank overdraft charges and late payment charges;
5. Legal and related expenses for challenges to decisions made by governmental agencies except for successful challenges as provided for in Section 10 - Property Costs;
6. Costs incurred for activities directly related to influencing employees with respect to unionization;
7. Cost of memberships in sports, health, fraternal or social clubs or organizations, such as Elks, YMCA, country clubs, Knights of Columbus;
8. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies (including all dues unless an allocation of dues to such costs is provided);
9. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., Lions, Chamber of Commerce, Kiwanis, in excess of \$1,500 per cost reporting period;
10. Home office costs not otherwise allowable if incurred directly by the facility;
11. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors that include annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for SEC purposes, stock transfer agent fees, and stockbroker and investment analysis;
12. Corporate costs not related to resident care including reorganization costs, costs associated with acquisition of capital stock, 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. Fund raising 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 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 administration 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 subdivision if that cost arises out of a transaction completed before July 18, 1984;
18. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises;
19. Depreciation expense for facility assets not related to resident care;
20. Nonnursing facility operations and associated administration costs;
21. Direct costs or any amount claimed to Medicare for Medicare utilization review costs;
22. All costs for services paid directly by the department to an outside provider, such as prescription drugs;
23. Travel costs involving the use of vehicles not exclusively used by the facility except to the extent:
 - a. The facility supports vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care;
 - b. Resident-care related vehicle travel costs do not exceed a standard mileage rate established by the Internal Revenue Service; and
 - c. The facility documents all costs associated with a vehicle not exclusively used by the facility;
24. Travel costs other than vehicle related costs unless supported, reasonable and related to resident care;
25. Additional compensation paid to an employee, who is a member of the board of directors, for service on the board;
26. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid, per day, to a member of the legislative council, pursuant to North Dakota Century Code section 54-35-10;

27. Travel costs associated with a board of directors meeting to the extent the meeting is held in a location where the organization has no facility.
28. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion of the cost that relates to costs that benefit all eligible employees;
29. Employment benefits associated with salary costs not includable in a rate set under this chapter;
30. Premiums for top management personnel life insurance policies, except that the premiums must be allowed if the policy is included within a group policy provided for all employees, or if the policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the sole beneficiary;
31. Personal expenses of owners and employees, including vacations, personal travel, and entertainment;
32. Costs not adequately documented through written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities;
33. The following taxes:
 - a. Federal income and excess profit taxes, including any interest or penalties paid thereon;
 - b. State or local income and excess profit taxes;
 - c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes on the issuance of bonds, property transfers, or issuance or transfer of stocks, generally either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;
 - d. Taxes, including real estate and sales tax, for which exemptions are available to the provider;
 - e. Taxes on property not used in the provision of covered services;
 - f. Taxes, including sales taxes, levied against the residents and collected and remitted by the provider;
 - g. Self-employment (FICA) taxes applicable to persons including individual proprietors, partners, or members of a joint venture.
34. The unvested portion of a facility's accrual for sick or annual leave;
35. The cost, including depreciation, of equipment or items purchased with funds received from a local or state agency, exclusive of any federal funds unless identified as an offset to cost exception in subdivision h of subsection 1 of section 13 ;
36. Hair care, other than routine hair care, furnished by the facility;

37. The cost of education unless:
- a. The facility is claiming an amount for repayment of an employee's student loans related to educational expenses incurred by the employee prior to the current cost report year provided:
 - (1) The education was provided by an accredited academic or technical educational facility;
 - (2) The allowable portion of a student loan relates to education expenses for materials, books, or tuition and does not include any interest expense;
 - (3) The education expenses were incurred as a result of the employee being enrolled in a course of study that prepared the employee for a position at the facility, and the employee is in that position; and
 - (4) The facility claims the amount of student loan repayment assistance for work performed by the employee in the position for which the employee received education, provided the amount claimed per employee may not exceed an aggregate of fifteen thousand dollars, and in any event may not exceed the cost of the employee's education.
 - b. The facility is claiming education expense for an individual who is currently enrolled in an accredited academic or technical educational facility provided:
 - (1) The education expense is for materials, books, or tuition;
 - (2) The facility claims the education expense annually in an amount not to exceed the individual's education expense incurred during the cost report year;
 - (3) The aggregate amount of education expense claimed for an individual over multiple cost report periods does not exceed fifteen thousand dollars; and
 - (4) The facility has a contract with the individual which stipulates a minimum commitment to work for the facility of six thousand six hundred fifty-six hours of employment after completion of the education program, as well as a repayment plan if the individual does not fulfill the contract obligations. The number of hours of employment required may be prorated for an individual who receives less than fifteen thousand dollars in assistance.
38. 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;

39. At the election of the provider, the direct and indirect costs of providing therapy services to nonnursing facility residents, third party payer therapy services or Medicare Part B therapy services, including purchase of service fees and operating or property costs related to providing therapy services;
40. Costs associated with or paid for the acquisition of licensed nursing facility capacity;
41. Goodwill;
42. Lease costs in excess of the amount allocable to the leased space as reported on the Medicare cost report by a lessor who provides services to recipients of benefits under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act;
43. Salaries accrued at a facility's fiscal yearend but not paid within seventy-five days of the cost report yearend;
44. Supplemental payments not offset to costs; and
45. Alcohol and tobacco products.

Section 13 – Offsets to Costs

1. Several items of income must be considered as offsets against various costs as recorded in the books of the facility. Income, in any form, received by the facility must be offset up to the total of the appropriate allowable costs with the following exceptions:
 - a. An established rate;
 - b. Income from payments made under the Workforce Investment Act;
 - c. Bed reduction incentive payments;
 - d. Donations;
 - e. The deferred portion of patronage dividends credited to the facility and not previously offset;
 - f. Income from charges for private rooms or special services;
 - g. Noncovered bed hold days; or
 - h. Sales tax revenue received from a political subdivision or local taxing authority for a facility located in a community with a population of less than twelve thousand five hundred people.
2. If actual costs are not identifiable, income must be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. Sources of income include, but are not limited to:

- a. "Activities income". Income from the activities department and the gift shop must be offset to activity costs.
- b. "Vending income". Income from the sale of beverages, candy, or other items must be offset to the cost of the vending items or, if the cost is not identified, all vending income must be offset to the cost category where vending costs are recorded.
- c. "Dietary income". Amounts received from or on behalf of employees, guests, or other nonresidents for meals or snacks must be offset to dietary and food costs.
- d. "Drugs or supplies income". Amounts received from employees, doctors, or others not admitted as residents must be offset to nursing supplies. Medicare Part B income for drugs and supplies must be offset to nursing supplies.
- e. "Insurance recoveries income". Any amount received from insurance for a loss incurred must be offset against the appropriate cost category regardless of when or if the cost is incurred if the facility did not adjust the basis for depreciable assets.
- f. "Interest or investment income". Interest received on investments, except amounts earned on funded depreciation or from earnings on gifts where the identity remains intact, must be offset to interest expense.
- g. "Laundry income." All amounts received for laundry services rendered to or on behalf of employees, doctors, or other nonresidents must be offset to laundry costs.
- h. "Private duty nurse income". Income received for the providing of a private duty nurse must be offset to nursing salaries.
- i. "Rentals of facility space income". Income received from outside sources for the use of facility space and equipment must be offset to property costs.
- j. "Telephone income". Income received from residents, guests, or employees must 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 must be offset to therapy costs unless the provider has elected to make therapy costs nonallowable under subsection 39 of Section 12.
- l. "Bad Debt Recovery". Income for bad debts previously claimed must be offset to property costs in total in the year of recovery.
- m. "Other cost-related income". Miscellaneous income, including amounts generated through the sale of a previously expensed or depreciated item, such as supplies or equipment, must be offset, in total, to the cost category where the item was expensed or depreciated.
- n. "Medicare Part B income". Income from Medicare Part B must be offset to the cost category where the expense is recorded.

3. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased.
4. Payments to a provider by its vendor must ordinarily be treated as purchase discounts, allowances, refunds, or rebates even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor. Payments that represent a true donation or grant need not be treated as purchase discounts, allowances, refunds or rebates. Examples of payments that represent a true donation or grant include contributions made by a vendor in response to building or other fundraising campaigns in which communitywide contributions are solicited or when the volume or value of purchases is so nominal that no relationship to the contribution can be inferred. The provider shall provide verification, satisfactory to the department, to support a claim that a payment represents a true donation.
5. Where an owner, agent, or employee of a provider directly receives from a vendor monetary payments or goods or services for the owner's, agent's, or employee's personal use as a result of the provider's purchases from the vendor, the value of the 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.
6. Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to costs of the provider and may not be treated as income by the central unit or organization or used to reduce the administrative costs of the central unit or organization.

Section 14 – Home Office Costs

1. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to member facilities. Although the home office of a chain is normally not a provider in itself, it may furnish central administration or other services including centralized accounting, purchasing, personnel, or management services. To the extent the home office furnishes services related to resident care to a facility, the reasonable resident related costs, not to exceed actual costs of the services, are includable in the facility's cost report and are includable as part of the facility's rate.
2. Where the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.
3. Home office costs incurred for expansion of a chain organization must be directly allocated to the appropriate component of the chain. The costs of abandoned plans are not allowable.
4. Central or home office costs representing services of consultants required by law in areas for social services, nursing, therapies or activities and central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing or therapies may be allocated to the appropriate cost category of a facility according to subsections a through e.
 - a. Only the salaries and employment benefits associated with the individual performing the service may be allocated. No other costs may be allocated.

- b. The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services in the facility.
- c. The cost in subdivision a for each consultant may not be allocated to more than one cost category in the facility. If more than one facility is served by a consultant, all facilities shall allocate the consultant's cost to the same operating category.
- d. Top management personnel may not be considered consultants.
- e. An allocation may not be made unless the consultant's full-time responsibilities are to provide the services identified in this section.

Section 15 – Related Organizations

1. Except as provided in subsection 3, costs applicable to services, facilities, and supplies furnished to a provider by a related organization may not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere primarily in the local market. The provider shall identify the related organizations and costs in the cost report.
2. A provider may lease a facility from a related organization within the meaning of rate setting principles. In such case, the rent paid to the lessor by the provider is not allowable as cost unless the rent paid is less than the allowable costs of ownership. If rent paid exceeds the allowable costs of ownership, the provider may include the allowable costs of ownership of the facility. These costs are property insurance, depreciation as provided for in Section 18 - Depreciation, interest on the mortgage as provided for in Section 19 - Interest Expense and real estate taxes as provided for in Section 20 - Taxes. Other operating expenses of the related organization relating to the leased facility are not includable by the provider as an allowable cost of ownership, but may be included as allowable operating expenses subject to subsection 1.
3. In the case of a facility acquired through purchase of shares, interest and depreciation expense are treated in the same manner as if the capital assets of the acquired corporation were acquired as an ongoing operation by the acquiring entity on the day the secretary of state issues a certificate of dissolution of the acquired corporation if organized in North Dakota, or on the day the acquired corporation is irrevocably dissolved if organized other than in North Dakota, provided the transaction has all of the following characteristics:
 - a. The facility was owned and operated by the acquired corporation;
 - b. The acquired corporation is irrevocably dissolved, and all of its capital assets become the property of the acquiring entity, within one year after the first day on which any ownership interest in the acquired corporation was acquired by the acquiring entity; and
 - c. Neither the acquiring entity nor any related organization of the acquiring entity has had any ownership interest in the acquired corporation, or any ownership

interest in any related organization of the acquired corporation, for at least ten years prior to the day the acquiring entity, or a related organization of the acquiring entity, first acquired any ownership interest in the acquired corporation.

4. For purposes of subsection 3, "acquiring entity" means the entity that, upon dissolution of the acquired corporation, owns all the capital assets formerly owned by the acquired corporation.

Section 16 – Compensation

1. Compensation on an annual basis for top management personnel must 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 report year, at least equal to the licensed capacity of the smallest facility within the top quartile of all facilities ranked by licensed capacity. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation divided by 365 times the number of calendar days the individual was employed.
2. 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 facility.
 - 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.
 - 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 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 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 determined to be the limitation in subsection 1 divided by two thousand eighty.
5. Costs otherwise nonallowable under this chapter may not be included as 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 all requirements of this subsection are met.
 - a. The bad debt must result from nonpayment of the payment rate or part of the payment rate.
 - b. The facility shall document 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 may not result from the facility's failure to comply with federal and state laws, state rules, and federal regulations.
 - e. The bad debt may not result from nonpayment of a private room rate in excess of the established rate, charges for special services not included in the established rate or charges for bed hold days not billable to the medical assistance program under Subsection 3, 4, 5, or 6 of Section 6.
 - f. The facility shall have an aggressive policy of avoiding bad debt expense that limits potential bad debts. The facility shall document that the facility has taken action to limit bad debts for individuals who refuse to make payment.
2. Allowable bad debt expense may not exceed debt associated with 180 days of resident care per year or a total of 360 days of resident care for any one individual.
3. Finance charges on bad debts allowable under subsections 1 and 2 are allowable only if the finance charges have been offset as interest income.

Section 18 – Depreciation

1. Rate setting principles require that payment for services includes depreciation on all capital assets used to provide necessary services.
 - a. Capital assets that may have been fully or partially depreciated on the books of the provider, but are in use at the time the provider enters the program, may be depreciated. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. To properly provide for costs or the valuation of such assets, an appraisal is required

if the provider has no historical cost records or has incomplete records of the capital assets.

- b. A depreciation allowance is permitted on assets used in a normal standby or emergency capacity.
- c. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the cost report. The facility shall use the sale price in computing the gain or loss on the disposition of assets.

2. Depreciation methods.

- a. The straight-line method of depreciation must be used. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, may not be used. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different than that submitted on the cost report, a reconciliation must be prepared by the facility.
- b. Except as provided in subdivision c, a provider shall apply the same methodology for determining the useful lives of all assets purchased after June 30, 1995. If a composite useful life methodology is chosen, the provider may not thereafter use the depreciation guidelines without the department's written approval. The provider shall use, at a minimum, the depreciation guidelines to determine the useful life of buildings and land improvements. The provider may use:
 - (1) A composite useful life of ten years for all equipment except automobiles and five years for automobiles; or
 - (2) The useful lives for all equipment identified in the depreciation guidelines and a useful life of ten years for all equipment not identified in the depreciation guidelines.
- c. A provider acquiring assets as an ongoing operation shall use as a basis for determining depreciation:
 - (1) The estimated remaining life, as determined by a qualified appraiser, for land improvements, buildings, and fixed equipment; and
 - (2) A composite remaining useful life for movable equipment, determined from the seller's records.

3. Acquisitions.

- a. If a depreciable asset has, at the time of its acquisition, historical cost of at least one thousand dollars, its cost must be capitalized and depreciated over the estimated useful life of the asset. Cost incurred during the construction of an asset, such as architectural, consulting and legal fees, and interest must be capitalized as a part of the cost of the asset.

- b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building repaired or maintained, or one-half of the original estimated useful life, whichever is greater.
- 4. Proper records must provide accountability for the fixed assets and provide adequate means by which depreciation can be computed and established as an allowable resident-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.
- 5. Donated assets, excluding assets acquired as an ongoing operation, may be recorded and depreciated based on their fair market value. In the case where the provider's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal may be made. The appraisal must be made by a recognized appraisal expert and shall be accepted for depreciation purposes. The useful life of a donated asset must be determined in accordance with subsection 2. The facility may elect to forego depreciation on a donated asset thereby negating the need for a fair market value determination.
- 6. Basis for depreciation of assets acquired as an ongoing operation.
 - a. Determination of the cost basis of a facility and its depreciable assets acquired as an ongoing operation depends on whether or not the transaction is a bona fide sale. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide.
 - (1) The cost basis of a facility and its depreciable assets acquired in a bona fide sale after July 1, 1985 is limited to the lowest of:
 - (a) Purchase price paid by the purchaser;
 - (b) Fair market value at the time of the sale; or
 - (c) The seller's cost basis, increased by one-half of the increase in the consumer price index for all urban consumers, United States city average, all items, from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes.
 - b. In a sale not bona fide, the cost basis of an acquired facility and its depreciable assets is the seller's cost basis, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer.
 - c. The cost basis of a facility and its depreciable assets acquired by donation or for a nominal amount is the cost basis of the seller or donor, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer or donee.

- d. In order to calculate the increase over the seller's cost basis, an increase may be allowed, under paragraphs (c) only for assets with a historical cost basis established separately and distinctly in the seller's depreciable asset records.
7. 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 effective July, 1 2015 is \$156,783 for double occupancy and \$235,176 for single occupancy.
 - b. 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.
 - c. 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.
 - d. 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.

Section 19 – Interest Expense

1. To be allowable, interest expense must meet all of the following criteria:
- a. Interest expense must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required. Repayment of working capital debt must be made within three years of the borrowing.
 - b. Interest expense must be identifiable in the facility's accounting records.
 - c. Interest expense must be related to the reporting period in which the costs are incurred.
 - d. Interest expense must be necessary and proper for the operation, maintenance, or acquisition of the facility. "Necessary" means that the interest is incurred on debt made to satisfy a financial need of the facility and for a purpose reasonably related to resident care. "Proper" means that the interest is incurred at a rate not in excess of what a prudent borrower would be obligated to pay in an arm's-length transaction and is incurred on debt obtained from a lender not related to the borrower through common ownership or control except for funds borrowed in accordance with Section 22 - Funded Depreciation.
 - e. Interest expense must not relate to funds borrowed to finance costs of assets in excess of the depreciable cost basis established at the time of purchase, construction, renovation or remodeling as recognized in Section 18 - Depreciation.

- f. If associated with borrowing for the purpose of acquiring assets as an ongoing operation in a bona fide sale, interest expense must be limited to the amount of interest associated with borrowing, occurring at the time of the sale, that does not exceed ninety percent of the cost basis as determined in Section 18.
 - g. In a sale not bona fide, interest expense may not exceed the amount that would have been allowable had the sale not occurred.
 - h. If associated with refinancing or refunding debt, interest expense associated with the original borrowing must have been allowable when the debt was initially incurred.
2. In cases where it is necessary to issue bonds for financing, any bond premium or discount must be amortized over the life of the bond issue.
 3. Interest paid by the provider to partners, stockholders, or related organizations of the provider is not allowable as a cost. Where the owner loans funds to a facility, the funds are considered capital, rather than borrowed funds.
 4. If a facility incurs interest expense because of late payments for resident services and charges a service charge or interest for late payments, the income must be offset against interest expense. If no interest expense is incurred by the facility because of late payments for resident services, service charges or interest paid must be offset against administration expenses.
 5. For refinanced or refunded debt, the total net aggregate allowable costs to be incurred for all reporting periods may not exceed the total net aggregate costs that would have been allowed had the refinancing or refunding not occurred. Annual allowable costs must be limited to the lesser of the cost that would have been allowed had the refinancing or refunding not occurred or the costs associated with the refinancing or refunding plus the portion, if any, of adjustments not recognized in prior cost reporting periods.
 6. Interest expense must be allocated between allowable and nonallowable expense based on the ratio of the principal balance of allowable debt to the principal balance of nonallowable debt at the time the debt was incurred except that the ratio may be adjusted to reflect principal payments on nonallowable debt made in excess of scheduled repayments, provided no funded depreciation or borrowed funds are used to make the excess principal payment.

Section 20 – Taxes

1. Taxes assessed against the provider, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense may not include fines, penalties, or those taxes identified as nonallowable costs in Section 12 - Nonallowable Costs.
2. Whenever exemptions to taxes are legally available, the provider is to take advantage of them. If the provider does not take advantage of available exemptions, the expense incurred for the taxes is not an allowable cost.

3. Special assessments in excess of \$1,000 paid in a lump sum, must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as billed by the taxing authority.

Section 21 – Startup Costs

In the first stages of operation, a new facility incurs certain costs in developing its ability to care for residents prior to admission. Staff is obtained, organized, and other operating costs are incurred during this time of preparation that cannot be allocated to resident care during that period because there are no residents receiving services. These costs are commonly referred to as startup costs. Actual allowable startup costs may be considered as deferred charges and allocated over a number of periods that benefit from the costs. Where a facility has properly capitalized startup costs as a deferred charge, the startup costs must be recognized as allowable costs amortized over sixty consecutive months starting with the month in which the first resident is admitted.

Section 22 – Funded Depreciation

1. Funding of depreciation is the practice of placing funds, including nonborrowed bond reserve and sinking funds, in a segregated account(s) for the acquisition of capital assets used in rendering resident care or for other capital purposes related to resident care. Other capital purposes include capital debt liquidation, such as principal payments for bonds and mortgages.
2. All provisions of this subsection must be met in order to qualify as funding of depreciation. If the provisions are not met, income earned on investments must be offset to interest expense.
 - a. The action to fund depreciation must be approved by the appropriate managing body of the facility.
 - b. The fund or funds must be clearly designated in the facility's records as funded depreciation accounts.
 - c. The total market value of the funded depreciation fund, including loans made pursuant to subsection 5, must be available, as provided in subsections 8 or 9, unless contractually committed on an as-needed basis for the acquisition of the facility's capital assets used to render resident care, or for other capital purposes related to resident care. Loans made from funded depreciation do not alter the requirement that funded depreciation must be available.
 - d. Income earned on investments in the fund must be deposited in and become part of the funded depreciation account.
 - e. Deposits to the funded depreciation account must remain for six months or more to be considered as funded depreciation. Deposits of less than six months are not eligible for the benefits of the funded depreciation account. Investment income earned prior to elapse of the six month period may not be offset unless

the deposits are actually withdrawn and then only if the withdrawal is not for capital purposes.

- f. Funded depreciation may not be restricted for a specific or future purpose.
 - g. When a provider invests or transfers the assets of the fund to a home office of a chain organization or the motherhouse or governing body of a religious order or to other related parties, the assets are considered to be the facility's funds and are subject to all provisions of this section.
3. Total funded depreciation from deposits in excess of accumulated depreciation on resident-related assets must be considered as ordinary investments and the income therefrom must be used to offset interest expense.
 4. Withdrawals for the acquisition of capital assets, the payment of mortgage principal on the assets and other capital expenditures are on a first-in, first-out basis. Withdrawals for general operating purposes or for loans to the general fund are made on a last-in, first-out basis.
 5. The facility may borrow from funded depreciation to obtain working capital for normal operating expenses used for resident care. In addition, the facility may borrow from funded depreciation accounts of related nursing and hospital facilities if the funded depreciation accounts of the related facilities are maintained in accordance with HCFA regulations. The interest incurred by the general fund is allowable provided the loans are necessary and proper, and provided the funds withdrawn have met the six month funding requirement. If the funds withdrawn do not meet the six-month funding requirement, interest paid on the loan is not an allowable cost. Funds loaned under the provisions of this paragraph are available funded depreciation. Costs incurred to secure lines of credit to ensure availability are not allowable costs.
 6. Interest paid by the general fund to the funded depreciation account is not an allowable cost if the facility borrows the funds to acquire capital assets. The facility is expected to use funded depreciation for that purpose.
 7. Deposits of funds into the funded depreciation account must be first applied to reduce loans outstanding from the funded depreciation account to the general fund. Until such loans, including related-party loans, are repaid in full, funds deposited in the funded depreciation account must be considered as repayments on the loans and any subsequent interest expense of the general fund to the extent of the repaid loans is not allowable.
 8. Available funded depreciation must be used before resorting to borrowing for the acquisition of capital assets or other capital purposes. Because it is frequently difficult to time a bond offering or other borrowing to coincide with the exhaustion of available funded depreciation, it is sufficient if available funded depreciation is contractually committed to and expended during the course of construction.
 9. Funds are considered available unless committed, by virtue of contractual arrangements, to the acquisition of capital assets used to render resident care, or to other capital purposes. Borrowing for a purpose intended by funded depreciation is unnecessary to the extent funded depreciation is available. Thus, interest expense for borrowing up to the amount of available funded depreciation is not an allowable cost.

10. When funded depreciation is used by the facility for other than the acquisition of capital assets, other capital purposes related to resident care, or loans to the general fund for current operating costs, the income earned on these funds while on deposit in the funded account must be adjusted in the report year the withdrawal was made. The adjustment must include all offsets not made in prior reporting periods for earnings applicable to the funds.
11. Borrowing for a purpose for which funded depreciation account funds may have been used makes the borrowing unnecessary to the extent that funded depreciation account funds were available at the time of the borrowing. Available funds in the funded depreciation account, to the extent of the unnecessary borrowing, are tainted funds. Interest expense incurred on borrowing for a capital purpose is not an allowable cost to the extent that funded depreciation account funds were available at the time of the borrowing.
12. A provider may remove the unnecessary characterization of borrowing, and thereby cure tainted funded depreciation, by using the tainted funds for a proper purpose described in subsection 1. Any funded depreciation that existed at the time of the unnecessary borrowing and is not classified as tainted must be used before any of the tainted funds.
13. When only a portion of the borrowing is considered unnecessary under subsection 11, subsequent repayments of the borrowing from general funds must first be applied to the allowable portion of the borrowing and then, when all of the allowable borrowing is repaid, to the unallowable portion of the borrowing. When funds from the funded depreciation account are used for the repayment of the unnecessary borrowing, an equivalent amount of tainted funds is cured without regard to the provisions of subsections 11 and 12. Where general funds are used to pay for the unallowable borrowing after the necessary borrowing has been repaid, an equivalent amount of tainted funded depreciation is cured without regard to the provisions of subsections 11 and 12.

Section 23 – Rate Calculations

For each cost category the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in Section 24 - Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs, divided by standardized resident days for the Direct Care cost category and resident days for Other Direct Care, Indirect Care and Property cost categories. The actual rate as calculated is compared to the limit rate for each category to determine the lesser of the actual rate or the limit rate. The lesser rate is given the rate weight of one. The rate weight of one for Direct Care is then multiplied times the weight for each classification in Section 32 - Classifications to establish the Direct Care rate for that classification. The lesser of the actual rate or the limit rate for Other Direct Care and Indirect Care, the Property rate and the adjustments provided for in Section 25 - Rate Limits and Incentives are then added to the Direct Care rate for each classification to arrive at the established rate for a given classification.

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

An adjustment factor may be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting the limit rates of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.

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, 2014. 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 must be established as follows:
 - (1) Historical costs for the report year ended June 30, 2014, as adjusted must be used to establish rates for all facilities in the Direct Care, Other Direct Care and Indirect Care cost categories. The rates as established must be ranked from low to high for each cost category.
 - (2) For the rate year beginning June 1, 2017, the limit rate for each cost category is:
 - (a) For the direct care cost category, \$178.18;
 - (b) For the other direct care cost category, \$28.15; and
 - (c) For the indirect care cost category, \$77.29.
 - (3) For the rate years beginning on or after June 1, 2017, the limit rate for each cost category is calculated based on:
 - (a) For the direct care cost category, the amount identified in subsection a(2)(a) of this section multiplied by the adjustment factor determined under Section 24;
 - (b) For the other direct care cost category, the amount identified in subsection a(2)(b) of this section multiplied by the adjustment factor determined under Section 24; and
 - (c) For the indirect care cost category, the amount identified in subsection a(2)(c) of this section multiplied by the adjustment factor determined under Section 24.
 - b. A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate.
2. 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.

3. 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 taking into consideration relevant factors including resident needs, nursing hours necessary to meet resident needs, size of the facility and the costs that must be incurred for the care of residents in an efficiently and economically operated facility. 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.
4. 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 the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of \$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, must be included as part of the Indirect Care cost rate.
5. A facility shall receive an operating margin of 3% based on the lesser of the actual Direct Care and Other Direct Care rates, exclusive of the adjustment factor, or the limit rate, in effect at the end of the year immediately preceding the rate year. The 3% operating margin must be added to the rate for the Direct Care and Other Direct Care cost categories.
6. The actual rate for Indirect Care costs and Property costs must be the lesser of the rate established using:
 - a. Actual census for the report year; or
 - b. Ninety percent of licensed bed capacity available for occupancy as of June 30 of the report year:
 - (1) Multiplied times three hundred sixty-five; and
 - (2) 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.
7. The department may waive or reduce the application of the ninety percent occupancy limit 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:
 - a. The facility has reduced licensed capacity; or
 - b. The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year affected by the ninety percent occupancy limit.
8. The department may waive or reduce the application of ninety percent occupancy limit for nongeriatric facilities for individuals with physical disabilities or geropsychiatric

facilities or units if occupancy below ninety percent is due to lack of department approved referrals or admissions.

Section 26 – Rate Adjustments

1. Desk Audit Rate

- a. The cost report must be reviewed taking into consideration prior year's adjustments. The facility shall be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.
- b. The desk audit rate must be effective January 1 of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.
- c. Until a final rate is effective as provided for in paragraph 2 of this section, private pay rates may not exceed the desk audit rate except as provided for in Section 4 - Participation Requirements or paragraph 3 of this section.
- d. The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's Medical Services Division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of Section 31. No decision on the request for reconsideration of the desk rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.
- e. The desk rate may be adjusted for special rates or one-time adjustments provided for in Section 28 - Special Rates or Section 29 - One-time Adjustments.
- f. The desk rate may be adjusted to reflect adjustments, errors, or omissions for the report year that result in a change of at least ten cents per day for the rate weight of one.

2. Final Rate

- a. 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 1 of each rate year unless the department specifically identifies an alternative effective date.
- b. The final rate must include any adjustments for nonallowable costs, errors or omissions that are found during a field audit or reported by the facility within twelve months of the rate year end and that result in a change from the desk audit rate of ten cents per day for the rate weight of one.

- c. The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in paragraph 3.a. of this section.
- d. The final rate may be revised at any time for special rates or one-time adjustments provided for in Section 28 or Section 29.
- e. If adjustments, errors or omissions are found after a final rate has been established, the following procedures must be used:
 - (1) Adjustments, errors or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least ten cents per day for the rate weight of one must result in a change to the final rate. The change must be applied retroactively as provided for in this section.
 - (2) Adjustments, errors or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least ten cents per day for the rate weight of one had they been included, must be included as an adjustment in the report year that the adjustment, error or omission was found.
 - (3) Adjustments resulting from an audit of home office costs, that result in a change of at least ten cents per day for the rate weight of one, must be included as an adjustment in the report year in which the costs were incurred.
 - (4) 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.

3. Pending Decision Rates for Private-Pay Residents

- a. If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per-day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.
- b. The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24-4.19, the total must be the rate chargeable to private-paying residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.
- c. The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-paying resident from the date the facility charges a private-paying resident the pending decision rate.

- d. If the pending decision rate paid by a private-paying resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.
4. Adjustment of the Total Payment Rate
 - a. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents.
 - b. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident if the established rate paid by the private-pay resident exceeds the final rate by at least \$1.00 per day, except that a pending decision rate is not subject to adjustment or refund until a final decision on the disputed amount is made.
 5. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds ten cents per day for the rate weight of one.

Section 27 – Rate Payments

1. The established rate must be considered as payment for all accommodations and includes all items designated as routinely provided. No payment may be solicited or received from the resident or any other person to supplement the rate as established except for instances expressly provided for in this manual.
2. The established rate must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.
3. If the established rate exceeds the rate charged to a private-pay resident on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay residents times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to the private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not

repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on refunds are not allowable costs.

4. The established rate is paid based on a prospective rate setting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically identified in other sections of this manual.
5. 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 the peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

Section 28 – Special Rates

1. For a new facility, the department shall establish an interim rate equal to the limit rates for Direct Care, Other Direct Care, and Indirect Care in effect for the rate year in which the facility begins operation, plus the Property rate. The Property rate must be calculated using projected property costs and projected census. The interim rate must be in effect for no less than 10 months and no more than 18 months. Costs for the period in which the interim rate is effective must be used to establish a final rate. If the final rates for Direct Care, Other Direct Care, and Indirect Care costs are less than the interim rates for those costs, a retroactive adjustment as provided for in Section 26 - Rate Adjustments must be made. A retroactive adjustment to the Property rate must be made to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for Property and Indirect Care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.
 - a. If the effective date of the interim rate is on or after March 1 and on or before June 30, the interim 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 by March 1 an interim cost report for the period ending December 31 of the year in which the facility first provides services. The interim cost report is used to establish the actual rate effective July 1 of the subsequent rate year. The partial year rate established based on the interim cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up. The cost reports for the report years ending June 30 of the current and subsequent rate years must be used to determine the final rate for the periods that the interim rate was in effect.
 - b. If the effective date of the interim rate is on or after July 1 and on or before December 31, the interim rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June 30 of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year. The facility shall file by March 1 an interim cost report for the period July 1 through December 31 of the subsequent rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the period that the interim rate was in effect.

- c. If the effective date of the interim rate is on or after January 1 and on or before February 29, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. The facility shall file a cost report for the period ending June 30 of the current rate year. This cost report must be used to establish the rate for the subsequent rate year. The facility shall file by March 1 an interim cost report for the period July 1 through December 31 of the current rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the period that the interim rate was in effect.
 - d. The final rate for Direct Care, Other Direct Care and Indirect Care costs established under this subdivision must be limited to the lesser of the limit rate for the current rate year or the actual rate.
2. For a facility with renovations or replacements in excess of \$100,000, and without a significant capacity increase, the rate established for Direct Care, Other Direct Care, Indirect Care, operating margins, and incentive based on the last report year, plus a Property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected Property rate must be effective at the time the project is completed and placed into service. 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. An interim Property rate must be established based on projected property costs and projected census. The interim Property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the Department of Health 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 at 95% 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 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.
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 four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and
 - (2) For a facility with less than four months of operation under the new ownership during the report year:
 - (a) By indexing the rates established for the previous owner forward using the adjustment factor in Section 24; or
 - (b) 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, by establishing a rate based on the previous owner's cost report.
- 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 four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and
 - (2) For a facility with less than four months of operation under the new ownership during the report year:
 - (a) By using the rate established for the previous owner for the previous rate year; or
 - (c) 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, by establishing a rate based on the previous owner's cost report.
- c. 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 principle 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 b, 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.
6. 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.

7. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using Subsection 2 or 3 and the property rate that would otherwise be established based on historical costs must be determined. The property rate established in each of the twelve years, beginning with the first rate year following the use of a property rate established using subsection 2 or 3 may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

Section 29 – One-Time Adjustments

1. Adjustments to Meet Certification Standards.
 - a. The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the North Dakota 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.
 - b. The facility shall submit a written request to the Medical Services Division within thirty days of submitting the plan of correction to the North Dakota 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 North Dakota Department of Health certification survey;
 - (2) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and
 - (3) Provide a detailed list of any other costs necessary to meet survey standards.
 - c. 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.
 - d. 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 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 a written request to the Medical Services Division containing the following information:
 - (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 nursing 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 26 - Rate Adjustments.

3. Adjustment to Historical Operating Costs

- a. 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 and when it has been determined the facility cannot meet the minimum standards through reallocation of costs and efficiency incentives.
- b. The following conditions must be met before a facility can receive the adjustment:
 - (1) The facility shall document, based on productive nursing hours and standardized resident days, the facility cannot provide a minimum of 1.2 nursing hours per standardized resident day;
 - (2) The facility shall document all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards; and
 - (3) 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.
- c. The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase must

be divided by standardized resident days and the amount calculated must be added to the rate. The rate is subject to any rate limitations that may apply.

- d. If the facility fails to implement the plan to increase nursing hours to 1.2 hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in Section 26 - Rate Adjustments.
 - e. If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.
4. Adjustments for disaster recovery costs when evacuation of residents occurs.
- a. A facility may incur certain cost 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.
 - b. 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.
 - c. Recovery costs must be identified as start-up costs and included as pass-through costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph d.
 - d. 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.
 - e. 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.
5. Adjustment for disaster recovery costs when no evacuation of residents occurs is not available.
6. Legislatively approved cost increases.
- a. The department shall increase rates otherwise established by N.D.A.C. 75-02-06 for supplemental payments or one-time adjustments to historical costs approved by the legislature.
 - b. Any additional funds made available by the supplemental payments or one-time adjustments must be used for the legislatively intended purpose 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 26.

Section 30 – Notification of Rates

1. The department shall notify each facility of the desk audit rate on or before November 22 of the year preceding the rate year, except a facility that has requested and received a cost reporting deadline extension of fifteen 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 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 private-pay residents that the rate increase is effective by the first day of the second month following the date of notification by the department. If the facility does not notify private-pay residents by the first day of the first month following notification by the department, the established rate in effect at the time of notification by the department must remain in effect until the first day of the month following the date the rate is payable by private-pay residents. No retroactive adjustment may be made to an established rate that remains in effect because the facility did not promptly notify private-pay residents unless the adjustment would result in a decrease of at least ten cents per day for the rate weight of one. 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.
3. If the department fails to notify the facility of the desk rate, as provided in subsection 1, the time required for giving written notice, as provided for in subsection 2, must be decreased by the number of days by which the department was late in setting the rate.

Section 31 – Reconsiderations and Appeals

1. Reconsiderations
 - a. Any requests for reconsideration of the final rate must be filed with the department's Medical Services Division within thirty days of the date of the rate notification.
 - b. A request for reconsideration must include:
 - (1) A statement of each disputed item and the reason or basis for the dispute;
 - (2) The dollar amount of each adjustment that is disputed; and
 - (3) The authority in statute or rule upon which the facility is relying for each disputed item.
 - c. The department may request additional documentation or information relating to a disputed item. If additional documentation is not provided within fourteen days of the department's request, the department shall make its determination based on the information and documentation available as of the fourteenth day following the date the department requested additional documentation.

- d. The department's Medical Services Division shall make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. Appeals

- a. A provider dissatisfied with the final rate established may appeal upon completion of the reconsideration process as provided for in Subsection 1. An appeal may be perfected by mailing or delivering, on or before five p.m. on the thirty-first day after the date of mailing of the determination of the Medical Services Division made with respect to a request for reconsideration. An appeal under this section is perfected only if accompanied by written documents including:
 - (1) A copy of the letter received from the Medical Services Division advising of that division's decision on the request for reconsideration;
 - (2) A statement of each disputed item and the reason or basis for the dispute;
 - (3) A computation and the dollar amount that 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; and
 - (5) The name, address, and telephone number of the person to whom all notices regarding the appeal may be sent.

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 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 group AAA is .45. Days for a 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 a hospital stay. The day of admission or return is counted as day one. The assessment reference date (A2300) on the MDS must be within the fourteen days.
 - 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 paragraph b.
 - d. An assessment must be submitted upon discontinuation of rehabilitation therapy if discontinuation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in paragraph b and the resident's classification is a rehabilitation classification.

4. A resident's classification is based on resident characteristics and health status recorded on the resident assessment instrument, including the ability to perform activities of daily living, diagnoses, and treatment received. The classification is determined using an index maximizing method. Index maximizing identifies all groups for which a resident qualifies and the resident is then classified in the group with the highest case mix index. The resident is first classified in one or more of seven major categories. The resident is then classified into subdivisions of each major category based on the resident's activities of daily living score and whether nursing rehabilitation services are needed or the resident has signs of depression. A resident meeting the criteria for more than one classification shall be classified in the group with the highest case-mix weight.
5. For purposes of this section:
 - a. A resident's activities of daily living score used in determining the resident's classification is based on the amount of assistance, as described in the resident assessment instrument, the resident needs to complete the activities of bed mobility, transferring, toileting, and eating;
 - b. A resident has a need for nursing rehabilitation services if the resident receives two or more of the following for at least fifteen minutes per day for at least six of the seven days preceding the assessment:
 - (1) Passive or active range of motion;
 - (2) Amputation or prosthesis care;
 - (3) Splint or brace assistance;
 - (4) Dressing or grooming training;
 - (5) Eating or swallowing training;
 - (6) Bed mobility or walking training;
 - (7) Transfer training;
 - (8) Communication training; or
 - (9) Urinary toileting, bladder, or bowel training program; and
 - c. A resident has sign of depression if the resident's total severity score for depression is at least ten based on the following:
 - (1) Little interest or pleasure in doing things;
 - (2) Feeling down, depressed, or hopeless;
 - (3) Trouble falling asleep or staying asleep or sleeping too much;
 - (4) Feeling tired or having little energy;
 - (5) Poor appetite or overeating;
 - (6) Feeling bad or failure or let self or others down;

- (7) Trouble concentrating on things;
- (8) Moving or speaking slowly or being fidgety or restless;
- (9) Thoughts of being better off dead or hurting self; or
- (10) Short-tempered or easily annoyed.

6. The major categories in hierarchical order are:

- a. Rehabilitation category. To qualify for the rehabilitation category, a resident must receive rehabilitation therapy. A resident who qualifies for the rehabilitation category is assigned a subcategory based on the resident's activities of daily living score.
 - (1) The rehabilitation category may be assigned within a classification period based upon initiation date if therapies are begun on any date not within the assessment reference period.
 - (2) The rehabilitation category may be discontinued within a classification period based upon discontinuation date if therapies are stopped on any date not within the assessment reference period and the resident's classification is a rehabilitation classification.
- b. Extensive service category. To qualify for the extensive services category, a resident must have an activities of daily living score of at least two and within the fourteen days preceding the assessment, received tracheostomy care or required a ventilator, respirator, or infection isolation while a resident.
- c. Special care high category.
 - (1) To qualify for special care high category, a resident must have at least one of the following conditions or treatments with an activities of daily living score of at least two:
 - (a) Comatose and completely dependent for activities of daily living;
 - (b) Septicemia;
 - (c) Diabetes with:
 - [1] Insulin injections seven days a week; and
 - [2] Insulin order changes on two or more days;
 - (d) Quadriplegia with an activities of daily living score of at least five;
 - (e) Chronic obstructive pulmonary disease and shortness of breath when lying flat;
 - (f) A fever in combination with:
 - [1] Pneumonia;

- [2] Vomiting;
 - [3] Weight loss; or
 - [4] Tube feedings while a resident that comprise at least:
 - [a] Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or
 - [b] Fifty-one percent of daily caloric requirements;
 - (g) Parenteral or intravenous feedings provided in and administered in and by the nursing facility; or
 - (h) Respiratory therapy seven days a week.
- (2) A resident who qualifies for the special care high category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.
- d. Special care low category.
- (1) To qualify for the special care low category, a resident must have at least one of the following conditions or treatments with an activities of daily living score of at least two:
- (a) Multiple sclerosis, cerebral palsy, or Parkinson's disease with an activities of daily living score of at least five;
 - (b) Respiratory failure and oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;
 - (c) Tube feedings while a resident that comprise at least:
 - [1] Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or
 - [2] Fifty-one percent of daily caloric requirements.
 - (d) Two or more stage two pressure ulcers with two or more skin treatments;
 - (e) Stage three or four pressure ulcer with two or more skin treatments;
 - (f) Two or more venous or arterial ulcers with two or more skin treatments;

- (g) One stage two pressure ulcer and one venous or arterial ulcer with two or more skin treatments;
 - (h) Foot infection, diabetic foot ulcer, or other open lesion of foot with application of dressing to the foot;
 - (i) Radiation treatment while resident; or
 - (j) Dialysis treatment while a resident.
- (2) A resident who qualifies for the special care low category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.
- e. Clinically complex category.
- (1) To qualify for the clinically complex category, a resident must have one or more of the conditions for the extensive services or special care categories with an activities of daily living score of zero or one or have at least one of the following conditions, treatments, or circumstances:
- (a) Pneumonia;
 - (b) Hemiplegia or hemiparesis with an activities of daily living score of at least five;
 - (c) Surgical wounds or open lesions with at least one skin treatment;
 - (d) Burns;
 - (e) Chemotherapy while a resident;
 - (f) Oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;
 - (g) Intravenous medication provided, instilled, and administered by staff within the facility while a resident; or
 - (h) Transfusions while a resident.
- (2) A resident who qualifies for the clinically complex category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.
- f. Behavioral symptoms and cognitive performance category. To qualify for the behavioral symptoms and cognitive performance category, a resident must have an activities of daily living score of less than six.
- (1) To qualify for the behavioral symptoms and cognitive performance category, a resident must either:
- (a) Be cognitively impaired based on one of the following:

- [1] A brief interview of mental status score of less than ten;
 - [2] Coma and completely dependent for activities of daily living;
 - [3] Severely impaired cognitive skills; or
 - [4] Have a severe problem being understood or severe cognitive skills problem and two or more of the following:
 - [a] Problem being understood;
 - [b] Short-term memory problem; or
 - [c] Cognitive skills problem.
- (b) Exhibit behavioral symptoms with one or more of the following symptoms:
- [1] Hallucinations;
 - [2] Delusions;
 - [3] Physical or verbal behavior symptoms directed toward others on at least four days in the seven days preceding the assessment;
 - [4] Other behavioral symptoms not directed toward others on at least four days in the seven days preceding the assessment;
 - [5] Rejection of care on at least four days in the seven days preceding the assessment; or
 - [6] Wandering on at least four days in the seven days preceding the assessment.
- (2) A resident who qualifies for the behavioral symptoms and cognitive performance category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.
- g. Reduced physical functioning category. To qualify for the reduced physical functioning category, a resident may not qualify for any other group. A resident who qualifies for the reduced physical functioning category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.
7. Except as provided in subsection 2, each resident must be classified into a case-mix class with the corresponding group label, activities of daily living score, other criteria, and case-mix weight as follows:

Group	Classification Category	ADL Score	Nursing Rehabilitation	Signs of Depression	Relative Weight
RAE	Rehabilitation	15-16			1.65
RAD	Rehabilitation	11-14			1.58
RAC	Rehabilitation	6-10			1.36
RAB	Rehabilitation	2-5			1.10
RAA	Rehabilitation	0-1			0.82
ES3	Extensive Services	2-16			3.00
ES2	Extensive Services	2-16			2.23
ES1	Extensive Services	2-16			2.22
HE2	Special Care High	15-16		Yes	1.88
HE1	Special Care High	15-16		No	1.47
HD2	Special Care High	11-14		Yes	1.69
HD1	Special Care High	11-14		No	1.33
HC2	Special Care High	6-10		Yes	1.57
HC1	Special Care High	6-10		No	1.23
HB2	Special Care High	2-5		Yes	1.55
HB1	Special Care High	2-5		No	1.22
LE2	Special Care Low	15-16		Yes	1.61
LE1	Special Care Low	15-16		No	1.26
LD2	Special Care Low	11-14		Yes	1.54
LD1	Special Care Low	11-14		No	1.21
LC2	Special Care Low	6-10		Yes	1.30
LC1	Special Care Low	6-10		No	1.02
LB2	Special Care Low	2-5		Yes	1.21
LB1	Special Care Low	2-5		No	0.95
CE2	Clinically Complex	15-16		Yes	1.39
CE1	Clinically Complex	15-16		No	1.25
CD2	Clinically Complex	11-14		Yes	1.29
CD1	Clinically Complex	11-14		No	1.15
CC2	Clinically Complex	6-10		Yes	1.08
CC1	Clinically Complex	6-10		No	0.96
CB2	Clinically Complex	2-5		Yes	0.95
CB1	Clinically Complex	2-5		No	0.85
CA2	Clinically Complex	0-1		Yes	0.73
CA1	Clinically Complex	0-1		No	0.65
BB2	Behavioral Symptoms/Cognitive Performance	2-5	Yes		0.81
BB1	Behavioral Symptoms/Cognitive Performance	2-5	No		0.75
BA2	Behavioral Symptoms/Cognitive Performance	0-1	Yes		0.58
BA1	Behavioral Symptoms/Cognitive Performance	0-1	No		0.53
PE2	Reduced Physical Functioning	15-16	Yes		1.25
PE1	Reduced Physical Functioning	15-16	No		1.17
PD2	Reduced Physical Functioning	11-14	Yes		1.15
PD1	Reduced Physical Functioning	11-14	No		1.06
PC2	Reduced Physical Functioning	6-10	Yes		0.91
PC1	Reduced Physical Functioning	6-10	No		0.85
PB2	Reduced Physical Functioning	2-5	Yes		0.70
PB1	Reduced Physical Functioning	2-5	No		0.65
PA2	Reduced Physical Functioning	0-1	Yes		0.49
PA1	Reduced Physical Functioning	0-1	No		0.45

8. The classification is effective the date the resident classification must be completed (the final day of the assessment reference period) in all cases except an admission or for a return from an acute hospital stay. The classification for an admission or for a return is effective the date of the admission or return.
9. A facility complying with any provision of this section that requires a resident assessment must use the minimum data set in a resident assessment instrument that conforms to standards for a resident classification system described in 42 CFR 413.333.

Section 33 – Appeal from Facility Transfer or Discharge

1. For purposes of this section:
 - a. "Discharge" means movement from a facility to noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident;
 - b. "Resident" includes a person who has been admitted and any legal representative of the resident; and
 - c. "Transfer" means movement from a facility to another institutional setting when the legal responsibility for the care of the resident changes from transferring facility to the receiving institutional setting.
2. Except as provided in subsection 4, a facility shall issue a written notice of involuntary transfer or discharge, that meets the requirements of subsection 3, at least thirty days before the date of intended transfer or discharge. The first day of that thirty-day period is the day after the date of issuance. The date of issuance is the day notice is delivered or mailed to the resident.
3. The notice provided by the facility must contain:
 - a. A statement that the facility intends to transfer or discharge the resident, as the case may be;
 - b. The reason for the transfer or discharge;
 - c. The effective date of the transfer or discharge;
 - d. The location to which the resident is to be transferred or discharged;
 - e. The specific provision of subsection 7 authorizing the transfer or discharge, or the change in federal or state law requiring the action;
 - f. A statement that the resident has the right to appeal the intended transfer or discharge to the department, and the mailing address to which an appeal must be sent;
 - g. The name, address, and telephone number of the state long-term care ombudsman;

- h. If the resident is intellectually disabled or mentally ill, the address and telephone number of the committee on protection and advocacy office that serves the area in which the resident resides;
 - i. If the Medicaid program is paying for some or all of the cost of services furnished to the resident by the facility, a statement that Medicaid payments shall continue under after the hearing unless:
 - (1) The sole issue at the hearing is one of state or federal law or policy and the resident is so informed in writing; or
 - (2) Some change in circumstances affects the resident's eligibility for medical benefits and the resident is so notified in writing;
 - j. A statement that the transfer or discharge shall be delayed, if a request for fair hearing is filed before the effective of the transfer or discharge:
 - (1) In the case of a discharge for nonpayment of facility charges, at least until the hearing officer recommends a decision that the charges were due and unpaid at the time the facility issued a notice of discharge; and
 - (2) In all other cases, until the fair hearing decision is rendered; and
 - k. A statement that the resident may represent him or herself at the hearing, or may use legal counsel, a relative, a friend, or other spokesperson.
4. a. A facility need not provide a notice under subsection 2 if the resident:
- (1) Provides a clear written statement, signed by the resident, that the resident does not object to a proposed transfer or discharge; or
 - (2) Gives information that requires a transfer or discharge and indicates that the resident understands that a transfer or discharge shall result.
- b. A facility must issue a notice that meets the requirements of subsection 3, as soon as practicable before an involuntary transfer or discharge when:
- (1) The safety of individuals in the facility is endangered;
 - (2) The health of individuals in the facility is endangered;
 - (3) The transfer or discharge is appropriate because the resident's health has improved sufficiently to allow a more immediate transfer or discharge;
 - (4) An immediate transfer or discharge is required by the resident's urgent medical needs that cannot be met in the facility; or
 - (5) The resident has not resided in the facility for thirty days.
5. A resident of a facility may appeal a notice from the facility of intent to discharge or transfer the resident. A resident has appeal rights when the resident is transferred from a certified bed to a non-certified bed or from a bed in a certified facility to a bed in a facility which is certified as a different provider. A resident has no appeal rights when the resident is moved from one bed in a certified facility to another bed in the same

certified facility. A resident has no appeal rights if the transfer or discharge has taken place and the resident did not appeal within thirty days after the date of issuance of a notice which meets the requirements of subsection 3.

6. If a resident with appeal rights files an appeal before the effective date of the transfer or discharge, the resident may not be transferred or discharged:
 - a. In the case of a discharge for nonpayment of facility charges, earlier than the date a hearing officer recommends a decision that the charges were due and unpaid at the time the facility issued a notice of discharge; and
 - b. In all other cases, until the fair hearing decision is rendered.

7. A facility may not discharge or transfer a resident unless:
 - a. The resident has an urgent medical need, which cannot be met in the facility;
 - b. The resident's physical condition endangers or poses a threat to the health or safety of the resident or other persons in the facility;
 - c. In cases involving a mental condition or behavioral problem, the behavior of the resident creates a serious and immediate threat to the resident or other residents or persons in the facility and all reasonable alternatives to transfer or discharge, consistent with the attending physician's orders, have been attempted and documented in the resident's medical record;
 - d. The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
 - e. The resident was accepted by the facility for the purpose of receiving specialized services and has fully benefited from those services or can no longer benefit from those services, provided that the purpose of the admission and the expected length of stay were agreed to, in writing, by or on behalf of the resident, prior to admission;
 - f. The resident's health or safety is at risk because the facility cannot reasonably accommodate the needs of the resident;
 - g. A public official with jurisdiction over matters of health or safety, in the performance of official duties, determines the health or safety of the resident is endangered by continued residence in the facility;
 - h. The facility's license is revoked, suspended, or not renewed, or the facility's participation in medicare or medicaid is terminated;
 - i. The facility intends to cease operations; or
 - j. The resident fails to pay, or to arrange for payment of, any part of charges based on the daily rate established under chapter 75-02-06, provided that no involuntary transfer or discharge may be based on a failure to pay charges for private rooms, bed holds in excess of fifteen consecutive hospital days or eighteen therapeutic leave days per calendar year, or special services not included in the daily rate.

Section 34 – Resident Personal Funds

1. A facility may not require a resident to deposit personal funds with the facility.
2. Upon written authorization of a resident or the resident's legal representative, a facility shall hold, safeguard, manage, and account for the resident's personal funds deposited with the facility.
3. A facility may not charge the resident for holding, safeguarding, managing, or accounting for the resident's personal funds. Any related administrative costs, including bank charges, must be included in the daily rate. The facility may not impose a charge against a resident's personal funds for any item or service included in the daily rate.
4. A facility may maintain a resident's personal funds that do not exceed fifty dollars in a non-interest bearing account. A facility shall deposit any resident's personal funds in excess of fifty dollars in an interest bearing account that is separate from any of the facility's accounts. A facility shall credit all interest earned to the resident's account.
5. A facility shall maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds. An individual financial record must be available on request and a written accounting of transactions must be provided quarterly to the resident or the resident's legal representative.
6. A resident's personal funds may not be commingled with any facility funds or with funds of any person other than another resident.
7. Upon death of a resident, the facility shall promptly convey the resident's personal funds, and a final accounting of those funds, to the individual administering the resident's estate. For purposes of this section, an "individual administering the resident's estate" includes a person lawfully empowered to facilitate the transfer of small estates without the use of a personal representative.
8. A facility shall purchase a surety bond or provide self-insurance to ensure the security of all resident personal funds deposited with the facility.

Section 35 – Specialized Rates for Extraordinary Medical Care

1. A specialized rate for an individual with extraordinary medical needs may be established if the criteria in both subdivisions a and b are met.
 - a. (1) The individual requires specialized therapies that are:
 - (a) Restorative in nature (restorative means the individual has the ability to improve);
 - (b) Medically necessary and provided in the facility;

- (c) Of at least two different types; and
 - (d) Provided in excess of fifteen hours per week;
 - (2) The individual requires extensive pulmonary care resulting from:
 - (a) Suctioning and related tracheostomy care performed by a licensed nurse or therapist in excess of three and one-half hours in a twenty-four hour period; or
 - (b) A drug-resistant respiratory infection;
 - (3) The individual requires total parenteral nutrition and:
 - (a) The individual is not eligible for or has been denied Medicare part A or B benefits; and
 - (b) The individual requires total parenteral nutrition based on medical necessity for a minimum of three months; or
 - (4) The individual requires the use of a ventilator and:
 - (a) Is dependent on the ventilator a minimum of six hours per day;
 - (b) Requires direct care by a licensed nurse, nurse aide, or therapist on a daily average of nine hours per day;
 - (c) Is physiologically stable; and
 - (d) Attempts to wean the individual from the ventilator have occurred during the acute hospital stay.
- b. Costs to provide direct care to the individual for the specialized services must exceed two and one-quarter times the actual direct care rate, adjusted for inflation, prior to limitation, for the individual's resident classification, except the department may use a cost limitation of one and three-quarters times the actual direct rate, if specialized equipment is purchased for use by the resident. Costs that may be included in determining if the cost factor is exceeded include salaries and fringe benefits of all direct care staff, nursing supplies, drugs, dietary supplements, and specialized equipment costs.
2. A specialized rate must be calculated for an individual who meets the criteria by subtracting the actual cost per day for direct care, prior to limitations, for the individual's classification from the total cost per day for the individual.
 3. A one-time startup cost of \$1,000 must be included in the initial specialized rate for the first thirty days after the effective date of the specialized rate.
 4. Except as provided for in subsection 7, all income received for a specialized rate must be offset proportionately to the affected cost categories.
 5. The facility shall report costs on a monthly basis for the first three full months after admission and on a quarterly basis thereafter. The specialized rates must be adjusted to actual on a prospective basis based on the report submissions.

6. The specialized rate must be paid in addition to the rate established for the individual's resident classification and may only be paid for in-house resident days.
7. If a specialized rate has been established and costs to provide direct care to the individual decrease to less than the cost limits provided for in subdivision b of subsection 1, the specialized rate must continue until the end of the rate year. Income from the specialized rate may not be offset to reported costs for the report year in which the costs to provide direct care to the individual decreased to less than the established cost limits.

Section 36 – Resident Transportation

1. For purposes of this section:
 - a. "Medical center city" means Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston, and includes any city that shares a common boundary with any of those cities; and
 - b. "Travel expenses" means fares, mileage, meals, lodging, and driver and attendant care.
2. A facility may not charge a resident for the cost of travel expenses for services provided by the facility. Except as provided in subsection 3, a facility shall provide transportation to and from any provider of necessary medical services located within, or at no greater distance than the distance to, the nearest medical center city. Distance must be calculated by road miles.
3. A facility is not required to pay for transportation by ambulance for emergency or nonemergency situations for residents.
4. A provider may not be compensated as a transportation service provider for transportation services provided an individual residing in the provider's facility.
5. If, under the circumstances, a facility is not required to transport a resident, and the facility does not actually transport the resident, the availability of transportation services and payment of travel expenses is governed by NDAC 75-02-02-13.1. Transportation services governed by NDAC 75-02-02-13.1 are not included in the facility's daily rate and are not a covered service.

APPENDIX A
LISTING OF ROUTINE DRUGS, SUPPLIES & DURABLE MEDICAL EQUIPMENT
(DME) FOR NURSING FACILITIES
Revised July 2018

ITEMS TO BE SUPPLIED BY FACILITY and INCLUDABLE ON COST REPORT INCLUDING
BUT NOT LIMITED TO:

Aerochamber/inhalaid
Alcohol (rubbing)
Ambu bag
Antacids
Antidiarrheals
Antihistamines
Antiseptic
Apnea monitors
Aspirin, Acetaminophen
Assistive listening device
Band-aids
Bandages, including Ace bandages
BIPAP, CIPAP machine and supplies
Blood glucose monitoring device, test strips and supplies (excluding diabetic)
Blood stool tester
Breath freshener
Cane
Catheter, tubing, bag & irrigating syringe
Clinistix, Ketostix, Dextrostix
Clinitest, Diastix, Ketodiastix, etc.
Commode chair
Compression stockings
Cotton
Cradle
Crutches
Denture cream, denture adhesive
Deodorant
Deodorizer
Dressings, Vigilon, Duoderm, Bioclusive, Tefla, etc.
Enemas, equipment and disposable
Facial tissue
Fall mats
Fall monitor
Finger cot
Fleece pad, sheep skin
Foam pad
Gait belt
Gastric feeding tube, sets, bags
Gauze, gauze pads, 4 x 4's
Geriatric chair
Gloves
Hand sanitizers
Harness, slings for lift
Hearing aid batteries and wax guards
Heating pad

Hemorrhoidal preparations
Hot water bottle
Humidifier
Hydrogen peroxide
Ice bag
Incontinence pads & briefs, sanitary napkins, disposable diapers
IPPB equipment and supplies
IV tray or subcutaneous tray and tubing
IV solutions without medication admixed
Lamps (Sun, SADD, psoriasis)
Larynx batteries
Laxatives
Lift, Hoyer, PAL, bariatric
Liniments
Lotions/creams
Lubricants, e.g., Vaseline, K-Y Jelly
Lymphoderma Device
Mouthwash
Needles, reusable and disposable (excluding diabetic)
Nebulizer
Ostomy supplies and related items
Oxygen, oxygen concentrator and supplies (cart, stand, mask, cannula, catheter),
Pump, Parenteral and Enteral and supplies
Q-Tips, applicators
Razor blades
Resident communication device
Restraints
Roho cushion
Seating system, non-customized
Shampoo
Soap
Sodium chloride for irrigation/inhalation
Specialized bed or mattress costing less than \$25 per day
Speech generating device
Splints
Stethoscope and examination tools
Suction machine and supplies
Stockings e.g. T.E.D. Jobst
Suppositories, glycerin
Suture tray
Syringes, all types (excluding diabetic)
Talcum powder
Tape, e.g., Micropore, surgical
Tennis balls for use on walkers
Tes-Tape
Thermometer
Toilet riser
Toothpaste, tooth powder, toothbrush
Tracheostomy supplies
Trapeze bar
Underpad
Vaccines, including but not limited to influenza, shingles and pneumonia vaccines

Vaporizer
Vitamins
Walker (including tennis balls)
Wander alert bracelet
Wheelchair

ITEMS EXCLUDABLE AS ROUTINE DRUGS, SUPPLIES, AND DME FOR NURSING FACILITIES and NOT INCLUDABLE ON COST REPORT:

Custom Seating Systems
Customized Shoes, including diabetic shoes
Diabetic Supplies routinely covered under Medicare Part D including syringes, needles, and swabs
Hearing Aids
Herbal Supplements
Insulin
IV and SQ Medication
IV Solution (if medication admixed)
Legend Drugs, except Influenza and Pneumonia Vaccines
Nicoderm CQ
Orthotics
Prosthetics
Repair to recipient-owned equipment
Specialized beds or mattresses costing \$25 or more per day
Vacuum assisted wound closure system and supplies
Ventilator