DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services

Instruction Manual

Annual Statistical and Cost Report of Nursing Facilities

For the Report Year October 1, 2024 through September 30, 2025

This manual has been prepared to assist Providers participating in the Minnesota Medical Assistance Program in completing the annual statistical and cost report of nursing facilities. The cost report, supplemental schedules and other data required to be submitted with this cost report provides the cost basis for the determination of rates to be paid to nursing facilities.

GENERAL INSTRUCTIONS

The deadline for submission of the Annual Statistical and Cost Report is 11:59 pm on February 1, 2026, or the 2025 cost report due date if that is extended.

The Department suggests that cost report preparers and others accessing the NF Portal use Google Chrome.

The Cost Report must be filed electronically via the NF Provider Portal. Some of the reporting fields will be pre-filled based on information from the previous year's Cost Report or other data sources. **This pre-filled information must be reviewed for accuracy and updated, if necessary**.

The electronic Cost Report on the NF Provider Portal contains multiple sections: **General Information, Beds, Resident Days, PDPM Days, Employee Data, Costs/Expenses, Assets/Debts/Leases, Scholarship Expenses, Bad Debt.** All sections must be completed prior to submission except the Bad Debt section which can be skipped if the provider is not claiming any bad debt. To navigate between these sections on the NF Provider Portal, use your mouse to click on the section titles listed on the left side of the screen.

Once the Cost Report is complete, click on "Run the Edit Report". The edit report will contain warning or error messages that must be corrected for the system to accept the Cost Report.

Warnings will be messages indicating that the data appears to be incorrect; the warning message will ask that the data be reviewed for accuracy. Additional messages will identify that a required field is missing an explanation or data input or there is inconsistent data that does not match throughout the report. These errors must be corrected for the system to accept the Cost Report.

You can exit the Cost Report and re-enter the report via the NF Provider Portal at any time. Any data entered during a previous session will be saved if you have chosen to save changes. The NF Provider Portal will automatically log you out of the system due to inactivity if the screen is left idle for 30 minutes or more.

Once you have corrected all errors and clicked the submit button, you will not be able to retrieve the Cost Report until several months after the Cost Report has been submitted. Print out a copy of the completed Cost Report for your records before the report is submitted.

Please contact the Department if you have submitted an incorrect report. Contact information is provided below.

Policy Questions

Any policy questions regarding the completion of the report which are not addressed in this manual should be directed to any of the following Department staff:

Shelly Jacobs	michelle.jacobs@state.mn.us	651-357-2040
Jane Gottwald	jane.gottwald@state.mn.us	651-470-7626
Heather Kamps Carlson	heather.k.carlson@state.mn.us	651-431-2604
Heidi Mercil	heidi.mercil@state.mn.us	651-431-5631

Technical Assistance

If you need technical assistance navigating the web-based application (NF Provider Portal or the NFRP Cloud), please contact:

Alicia Harrington alicia.harrington@state.mn.us

Submitting Multiple Cost Reports

If you are responsible for submitting multiple Cost Reports, there is an upload feature available which will allow you to upload a comma delimited text file which will pre-fill most of the line items in the Cost Report. After uploading, you will still need to review the Cost Report in the NF Provider Portal, complete the remaining required fields, such as entering explanations for adjustments, and run the edit report. The edit report must be reviewed, and any corrections entered before submitting the completed Cost Reports.

Incomplete, Inaccurate or Late Cost Reports

The Department may reject a Cost Report filed by a nursing facility if it is determined that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. If a Cost Report is rejected or is not submitted in a timely manner, the Department will reduce payments to a nursing facility to 85 percent of amounts due until the information is complete and accurately filed. The reinstatement of withheld payments will be retroactive for no more than 90 days.

Written notice of a potential payment reduction will be given to a nursing facility that does not file the annual Cost Report in a timely manner or in the event the submitted Cost Report is rejected by the Department for incomplete or inaccurate information. The written notice will allow the nursing facility the opportunity to correct the Cost Report and submit the report to the Department within 10 days before the payment reduction is implemented. The written notice will be emailed to the Administrator of the nursing facility via the facility email in the NF Provider Portal.

Administrator's Certification

The NF Provider Portal is a password protected site. The administrator has been provided a unique username and password. The password can be changed by the administrator after the initial log in. The facility administrator is responsible for security of the password. If the administrator provides the password to a staff person or other outside cost report preparer, they are delegating the authority to those individuals to certify that the Cost Report submitted is a true and complete statement prepared from the books and records of the nursing facility in accordance with applicable instructions.

Reporting Requirements

All data in the Cost Report must be based on the reporting period identified on the first page of this document.

Facilities submitting a Medicaid nursing facility Cost Report must remove all costs associated with non-nursing facility operations using the adjustments column on the Cost Report.

- "Nursing Facility Related Costs" column (Column 3) of the costs/expenses section of the report must contain only nursing facility related costs.
- Costs for items and services that are separately billable or reimbursed/reimbursable by any other pay source must be removed from the "Balance per Books" column (Column 1) using the "Adjustments" column (Column 2). This includes but is not limited to items and services that are billable to the resident(s) or resident responsible party, reimbursed under Minnesota Statutes 12A.10, MN Department

of Health grants, or Civil Monetary Penalty grants. Per Minnesota Statute 256R.02, Subd. 6, this also includes an expense reduction because of a purchase discount, rebate, refund, allowance, public grant, beauty shop income, guest meals income, adjustment for overcharges, insurance claims settlement, recovered bad debts, or any other adjustment or income reducing the costs claimed by a nursing facility.

- If your organization has non-certified boarding care or other beds, you must remove the costs associated with these beds in the "Adjustments" column.

Financial Reporting Requirements

Facilities are <u>required</u> to submit supporting information annually with the Cost Report in addition to the online electronic cost report form:

- **Supplemental Schedules:** Supplemental Schedules were created in Excel by the Department and emailed to the administrators at the email addresses listed in the NF Provider Portal. Providers are required to complete and submit the applicable pages of this Supplemental Schedule Excel workbook.
- **Cost Report and Supplemental Schedule Attestation:** Nursing facilities will be required to sign an attestation that the information contained within the Cost Report and Suppementl Schedules are true and correct. The attestation must be signed by the Administrator of Record or an authorized official of the Provider. The attestation cannot be signed by a contracted cost report preparer. Electronic signatures are not permitted.
- **Balance sheet and income statement** corresponding to the reporting year.
- **Working trial balance, including a reconciliation schedule between the working trial balance and the cost report for each nursing facility.** The reconciliation schedule must show how the "Nursing Facility Related Costs" Column (Column 3) of the cost report lines were calculated. If not, provide a mapping/grouping of expenses schedule.
- **Medicare Home Office Cost Report or applicable step-down allocation schedules**. If a provider submits costs on Line 8073 – Central Office Costs/Management Fees, the provider is required to provide a copy of the Medicare Home Office Cost Report or step-down allocation worksheet which ties out to the cost report. If the provider does not file a Medicare Home Office Cost Report but allocates costs to the nursing facility from a central/home office on Line 8073, the trial balance for the central/home office along with the allocation basis or calculation worksheet is required to be submitted in lieu of the Medicare Home Office Cost Report.
- **Hospital based facilities** allocating shared costs on the cost report should include a complete copy of the Medicare hospital cost report used for the allocation statistics and the worksheets detailing the step-down of the cost report shared expenses to the nursing home based on those statistics.
- **Cumulative Payroll Reports.** Providers are required to submit the cumulative payroll reports including departments and employee positions for all salaries reported on the cost report. If the salaries reported on the cost report include Corporate Office or internal pool float employees, please include a cumulative payroll report for those employees including the employee's name, position, and the cost report line

where the salary was reported. The cumulative payroll report for the internal float pool employees must identify which nursing facility(ies) the internal float employees worked.

- **All nursing facilities** that share services and/or space with non-nursing facilities must provide the working trial balance for the cost report ending date of the non-nursing facility operations that share services. The Department may request additional information upon further review.
- **All supporting documentation must be submitted by the due date of the Cost Report.** If the Department does not receive all the required documentation by the due date, the nursing facility will be notified and given ten days to submit the missing or inadequate documentation. If the Department does not receive the required documentation or the documentation is not adequate, the Department will issue a payment reduction to the reimbursement payments for the nursing facility equal to 85 percent of the payments due until the information has been received. The release of withheld payments must be retroactive for no more than 90 days.
- **DHS NFRP audit staff** will be reviewing the policies and procedures of the nursing facility relating to certain aspects of the costs reported within the DHS Annual & Statistical Cost Report. Per MN Statutes 256R.09 and 256R.13, nursing facilities are required to submit supporting documentation, when requested, that support costs and statistical information contained within the Cost Report. Please provide a full copy of the Employee Handbook and Employee Benefits Guide (if separate) for the RYE date identified on page one of this document. This would include the Employee Handbook and Employee Benefits Guide (if separate) for calendar year 2024 and 2025 for review. In addition, please provide copies of all policies and procedures relating to insurances and vacation/paid time off accruals that may be separate from the Employee Handbook and Employee Benefits Guide. If your nursing facility is part of a chain organization and each facility's information varies, then the information for each facility must be provided for review.
- **Audited financial statements for the facility.** If the nursing facility is part of a chain organization that has consolidated audited financial statements, a copy of the audited consolidated financial statements is required.
- **Leases and purchase agreements.** Provide copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility.
- **Disclosure of ownership of the nursing facility.** All nursing facilities must disclose ownership details on Schedule A-1 included in the DHS Supplemental Schedule.
- **Disclosure of ownership with related organizations (aka related party).** All owners with related-party(ies) having 5% or greater ownership must be disclosed on the Schedule A-2 related party schedule included in the DHS Supplemental Schedule.
- **Disclosure of any transactions with related organizations (aka related party) included in the cost report.** All related-party transactions must be disclosed on the related-party schedule included in the DHS Supplemental Schedule. A related organization is defined in MN Statute 256R.02, Subd. 43 as a person (individual, corporation, etc.) that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility.

The additional information and documentation must be submitted to the Department by 11:59 pm on February 1, 2026, or the 2025 cost report due date if that is extended:

- Email the DHS auditor listed on the Supplemental Schedule, or,
- Via the MN DHS Nursing Facility Rates and Policy SFTP service (aka NFRP Cloud). The NFRP Cloud is located here: https://secureftp.dhs.state.mn.us:8443 and requires your NFRP Portal login credentials to access. The NFRP Cloud should be used if the documentation submitted contains protected health information or employee information. If this method is used the nursing facility will need to email the DHS auditor that the additional information and documentation has been submitted via the NFRP Cloud. **The NRFP Cloud does not send an email to notify the DHS auditor that documentation has been uploaded**, or,
- DHS encourages all providers to submit supporting documentation electronically whenever possible. In addition to the environmental benefits of this approach, it is also more efficient from a time and cost perspective. Submitting hard copies via U.S. Mail will delay the processing of information. Should providers find it necessary to submit hard copies of documents, they may be submitted via U. S. Mail to the following address:
  Department of Human Services
  Nursing Facility Rates & Policy
  PO Box 64973
  St. Paul, MN 55164-0973

Record Retention Requirements

1. Facilities must maintain 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.

2. Accounting or financial information regarding related organizations must be readily available to substantiate costs. Home office cost reporting and cost allocation must comply with applicable sections in this manual and the Provider Reimbursement Manual paragraphs 2150 and 2153.

3. Each provider must maintain, for a period of not less than seven 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 must make such records available upon reasonable demand to representatives of the Department.

M.S. 256R.02 states in part; *"Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics.* It is the expectation of the Department that direct care worker position descriptions will document the requirement of a nursing license or certificate or TMA certificate, and, that the individuals working in these direct care positions will have a valid MN state nursing license or nursing certificate or TMA certificate during the applicable cost report period. Minnesota Statutes 256R.07 requires nursing facilities to retain adequate documentation to support its cost reports. This includes signed and dated position descriptions. Position descriptions must be in effect and retained by the facility during the cost report period to document the cost information reported on the Cost Report in accordance with M.S. 256R.07.

Position descriptions created after the cost report period do not meet the document retention requirements of M.S. 256R.07. To consider an employee's position description or any other information created after the end of the cost report period would circumvent this statutory requirement to maintain adequate documentation supporting a facility's cost on the Cost Report.

4. DHS will not consider a position description signed, dated, or created after the end of the applicable cost report period.

Hospital-attached Facilities

Hospital-attached facilities are required to complete only the "Hospital-attached Expense Not Directly Identified" lines (the line numbers that end in "95") of the Cost Report for all cost categories except as noted below. If the facility tracks direct expenses for some departments but not all, line-item detail may be reported for those departments where expenses are directly identified. If the nursing facility reports allocated fringe benefits on line 9095, they must include salaries either directly identified on lines 6313, 6413, 6513, 6613 and 8013 or not directly identified on lines 6395, 6495, 6595, 6695 and 8095. The nursing facility should not include portions of salaries on both the direct and indirect lines in each section. If the hospital-attached facilities report portions of salaries that are not directly identified on lines XX95, do not report the productive and compensated hours 0309, 0310, 0311, 0317, 0318, 0319, 0336, 0337, 0338, 0344, and 0345.

The amounts for the following lines (or other lines where expenses are directly identified) should be subtracted from the "Hospital-attached Expense Not Directly Identified" line in their corresponding category and reported on these individual lines:

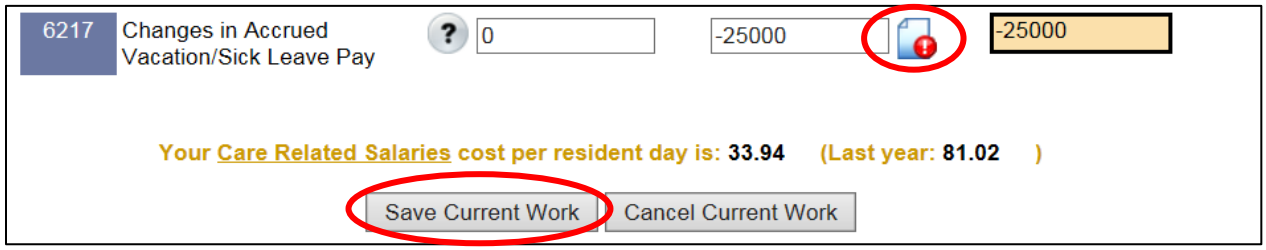
- Line 7011 - Surcharge Expense
- Line 7012 - Real Estate Taxes
- Line 7014 - Special Assessments
- Line 7015 - MDH Nursing Facility License
- Line 7017 – Scholarship Costs
- Line 7018 – PERA Contributions
- Line 7020 – Resident & Family Advisory Council Costs
- Line 9021 – Health Savings Account/Health Reimbursement Account (HSA/HRA)
- Line 9022 – Group Medical Insurance
- Lines 6111 through 6290 – Care Related Costs

Hospital-attached facilities are allowed to use the same step-down statistics as their Medicare fiscal year end for 2025. If the Medicare fiscal year end of the facility is after 9/30/2025, the facility has the option of using the 2024 Medicare cost report statistics (instead of 2025). A hospital-attached facility may also revise their step-down statistics to reflect actual 9/30/2025 statistics if their fiscal year for Medicare is not 9/30/2025. The facility must use the same option in subsequent years or seek approval from the Department if they wish to change. In all cases the actual year end costs at 9/30/2025 must be used for the step-down.

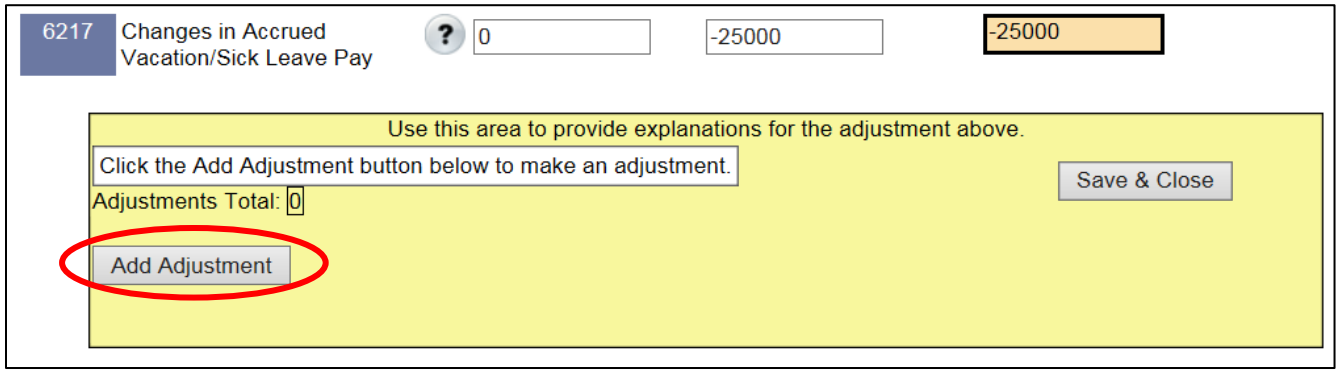
Entering Adjustments on the Cost Report

Step 1: To make an adjustment to the "Balance per Books" column of the Cost Report, the adjustment amount should be entered as either a positive or negative number in the "Adjustments" column on the electronic report

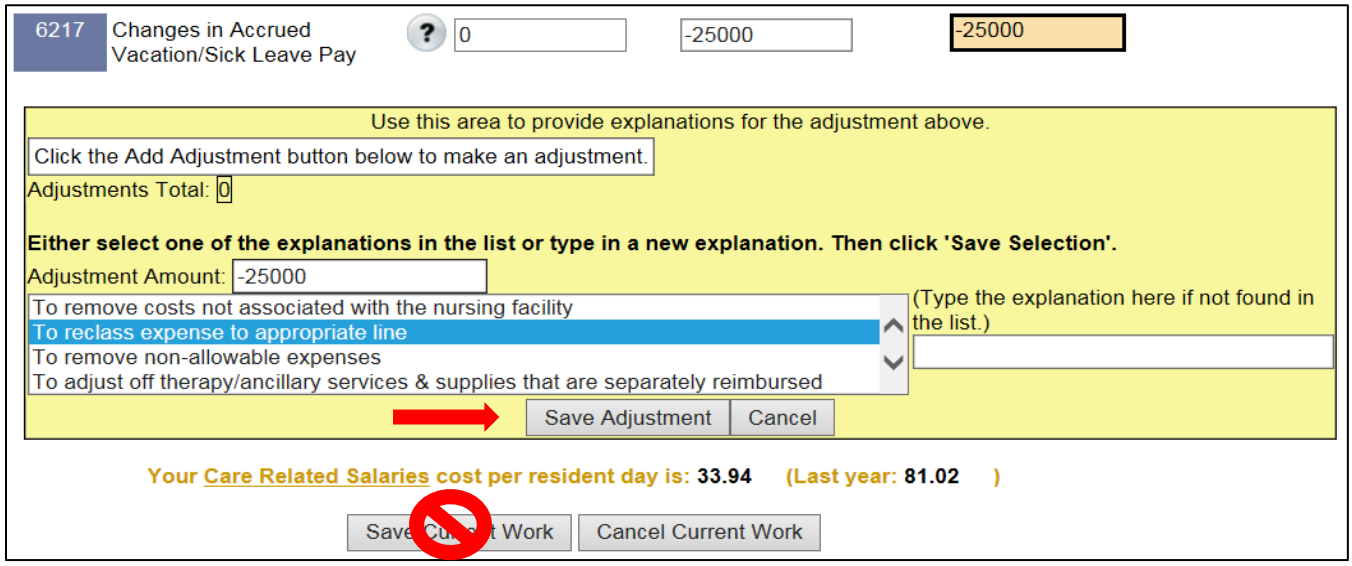
form. To save the entered adjustment, click “Save Current Work” (Do Not press the Enter Key) and a red icon will appear next to each entered adjustment as shown below:



Step 2: The red icon is a warning message to indicate that an explanation is required to be entered for the adjustment made in the “Adjustments” column. "Explanations of Adjustments Made to the Report" are to be entered if adjustments are made to any item on the Cost Report. Click the red icon which will open the adjustments window:



Step 3: To enter an explanation, click “Add Adjustment” and the following box will appear:

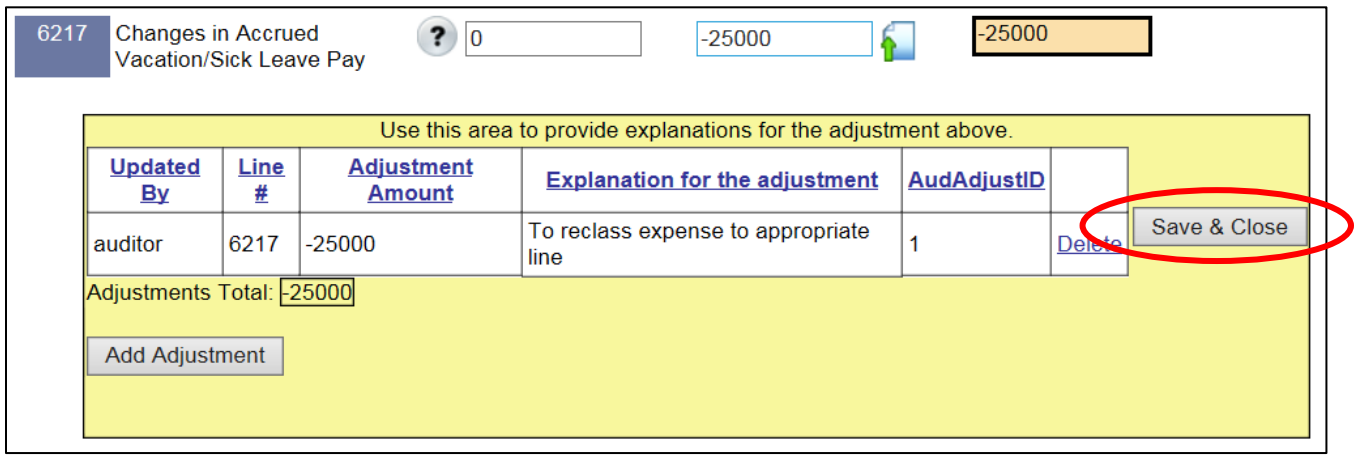


Step 4: Enter the amount of the adjustment in the box provided and select the adjustment explanation from the drop-down menu OR enter your own adjustment explanation in the box provided. NOTE: The system cannot accept more than one explanation; make sure to select either an explanation from the drop-down menu OR enter your own explanation. Explanations cannot contain protected health information. If both the drop-down menu explanation and your own explanation are selected, the system may error out.

IMPORTANT: To save the adjustment amount and explanation entered in the adjustments window, you must click the "Save Adjustment" button contained in the adjustments window. DO NOT CLICK "Save Current Work" below the adjustments window; the system may not properly save the adjustments entered in the adjustments window.

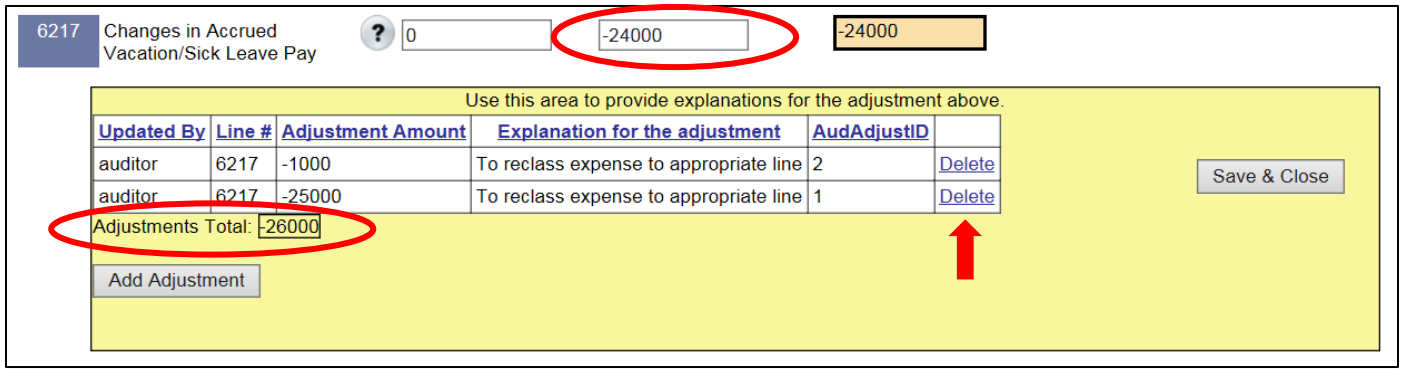
Multiple adjustment amounts and explanations can be entered for each Cost Report line in the adjustments window. After you have saved the first adjustment and explanation by clicking the "Save Adjustment" button, if you would like to add additional adjustment amounts and explanations in the same Cost Report line, follow Steps 3-4 again as outlined above.

Step 5: Once you are finished entering all the adjustment amounts and explanations on the Cost Report line, you must complete the entry by clicking the "Save and Close" button contained in the adjustments window:



Failure to complete the entry by clicking the "Save and Close" button contained in the adjustments window may cause the system not to save the adjustments you have entered.

IMPORTANT: The system will automatically total the adjustment amounts entered in the adjustments window and update the total column – the "Adjustments" column (Column 2). You should ensure Column 2 is the amount you are adjusting from the "Balance per Books" column. If the adjustment amounts entered in the adjustments window do not reconcile to Column 2, the system should generate a warning icon. Click on the icon (it should be red) and review the adjustment amounts entered in the adjustments window:



This error may occur when the amount in Column 2 is manually changed/updated, but the adjustment entries are not also updated. To fix this error, delete the incorrect adjustment entry by clicking "Delete" next to the entry. Enter a new adjustment entry to correct the error as previously instructed in Steps 3-5.

NOTE: If you have multiple adjustments and/or explanations for one Cost Report line, you **must** submit a separate explanation of adjustments worksheet. However, you are still required to enter an adjustment

summary in the adjustments explanation window. The adjustment summary should reference the separate explanation of adjustments worksheet used in lieu of entering the multiple explanations in the electronic form. The separate explanation of adjustments worksheet must identify the Cost Report line, adjustment amounts, and a detailed explanation for each adjustment which will be sufficient for an auditor to review what was adjusted on the Cost Report.

Section 1: General Information

Please review each of the data fields carefully and complete or change them as needed. Click on the nearest "*Save Current Work"* button to update the General Information page.

General and Ownership Information

Facility Licensed Name: Record the licensed name as it appears on the license granted by the Department of Health. If the licensed name is longer than 75 characters, abbreviate as necessary.

National Provider Identification (NPI) Number: Record the NPI number of the nursing facility.

Ownership Code (Type): An organization is considered to have control if it has the power, directly or indirectly, to direct or to significantly influence the actions or policies of another organization or institution.

Physical Plant Owner: The physical plant owner field must have a valid selection. Use the drop-down menu to select the type of entity that owned the physical building of the nursing facility on the last day of this cost reporting period. This may or may not be different than the ownership code. Note that Real Estate Investment Trust (REIT) is included in the drop-down menu.

Facility Telephone Number: The facility telephone number should be the telephone number for the nursing facility. The telephone number should not be for the corporate office or managing company.

Facility Email: The facility email should be the email address for the facility or the email address for the facility administrator. The email should not be for the corporate office or managing company.

Facility Administrator: The facility administrator should be the administrator of the facility **at the time that the cost report is filed**; not the administrator on the last day of the cost report period. The facility administrator should not be for the corporate office or managing company.

Admissions during report year: Record the total number of NF and NFII resident admissions (Medicaid and non-Medicaid).

Legal Business Name as reported to the Internal Revenue Service (IRS): Record the name of the parent or controlling organization as it appears in the records of the IRS. If the name is longer than 40 characters, abbreviate as necessary.

Controlling Organization: Record the name of the parent or controlling organization as it appears in the records of the Minnesota Secretary of State offices or in the Secretary of State offices of the state where the parent/controlling organization was formed. If the name is longer than 40 characters, abbreviate as necessary. An organization is considered to have control if it has the power, directly or indirectly, to influence or significantly direct the actions or policies of another organization or institution.

Number of facilities: The Minnesota facilities line must be at least "1" (for this facility).

Other Minnesota facilities: Record the name and provider ID of all Minnesota related nursing facilities. Related facilities include all affiliate nursing facilities under common ownership or control. If the facility was acquired through a Change of Ownership (CHOW) during the cost reporting year and the name of the facility has changed, the facility name must be updated. If the provider ID changed during the cost report year, please update the provider ID.

Was this facility hospital attached during any part of this cost reporting period? If the answer is "Yes" the facility will need to submit the completed Medicare Cost Report to DHS for the applicable cost report period. The hospital attached facilities should not complete the Cost Allocation Schedule on the General Information Page.

Did the kitchen (or kitchens) in this nursing facility prepare meals for anyone in addition to residents of this nursing home at any time during this report year? If yes, you are **REQUIRED** to complete the Dietary Allocation Schedule and input the necessary associated adjustments on the appropriate lines of the cost report form before submitting it.

Does this Cost Report include dietary costs on Line 6300 that have been adjusted for non-nursing home dietary costs, either prior to the balance per books amount being entered or in the adjustment column of this line? If yes, you are **REQUIRED** to complete the Cost Allocation Schedule on the General Information Page.

Does the nursing facility VACATION or Paid Time Off (PTO) policy give unconditional rights to the employees for earned benefits including upon termination? If yes, please complete the spreadsheet included in the Supplemental Schedule.

Does the nursing facility's SICK LEAVE policy give unconditional rights to the employees for the earned benefits including upon termination? If yes, please complete the spreadsheet included in the Supplemental Schedule.

During the cost report year, did the nursing facility update their PTO/Vacation/Sick policies? If so, the Department requires a copy of the revised policy(ies) for review.

Section 2: Beds Data

General

The Licensed & Certified Beds section is for the recording of bed status and the types of changes to bed status during the reporting year.

0090

The number of licensed beds in active service on the first day of the reporting year has been pre-filled based on the information reported at the end of the previous report year. Active service means beds that are being used by a resident or can be filled by a resident at any time.

0095

The number of licensed beds in layaway status on the first day of the reporting year has been pre-filled based on the information reported at the end of the previous cost report year.

Change in number of beds

This section is to record changes in bed status during this cost reporting year. Any bed changes that occurred before the beginning of this cost report period as identified on page one of this document have been presented for you to review and edit if necessary. Record changes in bed status by type of change, the date of change, and the number of beds changed. Record all bed changes as positive values. The change types are:

- Placed on layaway (beds removed from active service and the layaway was recognized by MDH)
- Removed from layaway (beds removed from layaway and placed back into active service per MDH approval)
- Permanently delicensed (beds de-licensed / closed)
- Beds acquired from a different facility (relocation of beds to this facility; this requires MDH approval)
- Relocated to a different facility (bed(s) removed from this facility and transferred to a different facility; this requires MDH approval)

If beds previously placed on layaway were delicensed during this reporting period, first record the removal of beds from layaway and then record the permanently delicensed beds.

0264 - 0268

- Single-bed rooms are those where a bed does not share access to the corridor with another bed. A private room is a single-bed room that has a toilet area that it does not share with another bed. Two single-bed rooms that have a toilet area between them and each bed has a door to the toilet area are not private rooms; they are to be reported as single-bed rooms.
- Split-double rooms are those where two beds share access to the corridor, but there is a fixed, floor to ceiling, partition that physically splits the room in two.
- Double-bed rooms are those where two beds share access to the corridor and there is no fixed partition separating the beds.
- Three- and four-bed rooms are those where the given number of beds shares access to the corridor.

When completing this table, enter the number of beds in each of these configurations as of the last day of the reporting period and not the number of rooms. Do not report beds that have been put on layaway.

Bed configurations from the prior report year are displayed for your review. If the bed configurations reported on your previous Cost Report contains an error, please contact the Department using the contact information in the General Instructions section of this document.

0273

Record the number of Medicare-certified skilled beds in active service at the end of the reporting year.

Single/Private-bed room Differentials

Report the amount(s) *currently* charged for a single-bed room (a.k.a., the private room differential).

Section 3: Nursing Facility Resident Days

5001 - 5050

Total Nursing Facility resident days must be broken down into the 50 categories under the MINNESOTA Case Mix Classification RUGS-IV System for dates of service within the reporting period identified on page one of this document. Record the RUG determination made by the Department of Health to classify each of the residents. The total days must be broken down to the proper column (Private Pay, Medicaid, Medicare Part A, Other). List nursing home residents only (NF Rule 80 and NF non-Rule 80) on these lines. The reporting of Resident Days in this section should include all NF Days, including those Resident Days provided in non-NF spaces under a MN Department of Health (MDH) waiver.

“Medicare Part A” means a nursing facility resident who is receiving Medicare Part A skilled services of which Medicare days (also known as Medicare Fee-for-Service) are billed through a Medicare intermediary. Medicare replacement plans such as UCare, Medica, Humana, etc. must have these days reported as “Other”.

Examples of "Other" days include Veterans Administration, Railroad, HMO, LTC Insurance, and Managed Care Health Plans (i.e. MSHO, MSC+). Hospice days should be reported by whichever payor was reimbursing the nursing home for room and board, typically either Private Pay or "Other." For example, if a hospice agency is paying the nursing home for room and board, the days should be reported as "Other" days regardless of who is paying the hospice agency. **Unpaid bedhold days are not to be included in the report.**

"Private pay" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or Medicare. A nursing facility resident who has an application pending with Medicaid (aka Medicaid Pending) must have these days reported as “Private Pay”.

NOTE: If the facility had resident days at a penalty classification, these days are to be reported as resident days at the MINNESOTA Case Mix RUG class established immediately after the penalty period, if available, and otherwise, at the MINNESOTA Case Mix RUG class in effect just prior to when the penalty period began. See MN Statutes, Section 256R.02, Subd. 50.

Board and Care (NF II) Resident Days

5051 - 5100

NF II resident days are to be listed on these lines. Do NOT include resident days provided in Board and Care licensed beds that are not certified as NFII.

NOTE: If the facility had resident days at a penalty classification, these days are to be reported as resident days at the MINNESOTA Case Mix RUG class established immediately after the penalty period, if available, and otherwise, at the MINNESOTA Case Mix RUG class in effect just prior to when the penalty period began.

Section 4: Patient Driven Payment Model (PDPM) Resident Days

5201 - 5227

The completion of the PDPM Resident Days on the cost report is not optional. All nursing facilities must complete this section prior to submission of the cost report. Nursing facilities that submit a cost report without the PDPM section being completed will be subject to a 15% payment withhold until the nursing facility sends the Department complete PDPM census data.

Total Nursing Facility resident days must be broken down into the 27 categories under the PDPM Case Mix Nursing Group (CMG) System for dates of service within the reporting period identified on page one of this document. Record the CMG determination to classify each of the residents. The total days must be broken down to the proper column (Private Pay, Medicaid, Medicare Part A, Other). List nursing home residents only (NF Rule 80 and NF non-Rule 80) on these lines. The reporting of Resident Days in this section shall include all NF Days, including those Resident Days provided in non-NF spaces under a MN Department of Health (MDH) waiver.

The PDPM Resident Days must equal the Nursing Facility Resident Days under the MN Case Mix Classification RUGS-IV System.

“Medicare Part A” means a nursing facility resident who is receiving Medicare Part A skilled services of which Medicare days (also known as Medicare Fee-for-Service) are billed through a Medicare intermediary. Medicare replacement plans such as UCare, Medica, Humana, etc. must have these days reported as “Other”.

Examples of "Other" days include Veterans Administration, Railroad, HMO, LTC Insurance, and Managed Care Health Plans (i.e. MSHO, MSC+). Hospice days shall be reported by whichever payor that would be reimbursing the nursing home for room and board, typically either Private Pay or "Other." For example, if a hospice agency is paying the nursing home for room and board, the days shall be reported as "Other" days regardless of who is paying the hospice agency. Unpaid bedhold days are not to be included in the report.

"Private pay" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or Medicare. A nursing facility resident who has an application pending with Medicaid (aka Medicaid Pending) must have these days reported as “Private Pay”.

NOTE: If the facility had resident days at a penalty classification, these days are to be reported as resident days at the MINNESOTA Case Mix CMG class established immediately after the penalty period, if available, and otherwise, at the MINNESOTA Case Mix CMG class in effect just prior to when the penalty period began. See MN Statutes, Section 256R.02, Subd. 50.

Section 5: Employee Data

Care Related Staff Retention

1619 - 1638

In column 1, record the number of employees on the first day of the report year (October 1). Include a part-time employee as one employee, not as a fraction of a full-time employee. Employees shared between two facilities under the same ownership or management should be counted as an employee for both facilities.

Van drivers/Transportation staff are to be included as a care related worker if they are nursing, social service, or activities staff and should be reported in those categories. A full-time van driver or an employee of a support service category such as maintenance should not be included in the care related employee data.

Seasonal employees should be counted as active employees if they are working at the end of the reporting period, or it is anticipated they will be working in the next 10 months or 300 days.

On-call employees: On-call employees are not to be included in the employee data. An on-call employee provides temporary services for the nursing facility and the nursing facility includes the employee on their payroll system. An on-call employee is not regularly scheduled at any time during the reporting period. A regularly scheduled part or full-time employee that changed to on-call status during this reporting period is to be counted as a termination.

Probationary employees: Employees are considered active employees on their hire date. Employees still in their probationary period at the beginning of the report year are included in the number of employees reported at the beginning of the report year.

1619 - 1638

In column 2, record the number of employees who were employed for the entire reporting year for each job category. In other words, of those listed in column 1, report how many were still employed on the last day of this reporting year. In column 2, do not include employees who transferred from listed categories to job categories other than those listed. Do include employees that transfer within these job categories. An employee transferring to another job category listed and still employed at the end of the report year, should be counted in the category where they started the report year.

1619

Nursing administration includes licensed nursing staff responsible for management of the nursing department or primarily responsible for record keeping. Examples of nursing administration staff include: DON, ADON, MDS coordinator, Medicare nurse, in-service educator, infection control nurses and quality coordinators. Staff performing administrative duties that are not licensed as a nurse, such as a unit coordinator, scheduler or medical records staff are not to be counted as care related nursing administration staff on line 1619; they are to be reported on line 1633.

1637

Activities staff includes: the supervisor and other activities workers including volunteer coordinators and recreation aides.

1638

Other Care Related Staff means any other staff providing care related services to residents including paid feeding assistants and religious personnel employed by the nursing facility. Room service attendants, dining room companions, and resident companions are not considered care related staff. Dietary aides and other support services staff who are not trained as feeding assistants should not be included. Volunteer coordinators should be reported on line 1637. Do not include licensed therapists or assistant therapists working under a licensed therapist's supervision performing billable therapy services. Generally, for retention reporting purposes, employees should be classified according to their certification or licensure category regardless of the job title. Universal workers who were C.N.A.s during the cost report period and whose time was primarily spent performing C.N.A. services should be reported on the C.N.A. line.

Care Related Staff Retention Rate is determined by the number of care related employees on the first day of the report year (October 1) that were still employed on the last day of the report year (September 30) divided by the number of care related employees on the first day of the report year (October 1).

Productive Hours

0301 - 0325

Generally, all hours worked by employees classified as care related workers are to be reported as productive hours, including **licensed nursing administrative** staff. This includes on-the-job training for both the trainee and the trainer.

Employees performing both care related and support services must have their hours and wages allocated between cost categories. The allocation methodology must be documented by the facility and be available upon request by the Department. Care related hours worked by Universal workers who are C.N.A.s should be allocated to the C.N.A. line. The proportion of hours related to non-care related duties such as housekeeping or dietary, are not to be included as productive care related hours. Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs between applicable cost categories. Effective October 1, 2025, the Department has implemented a new time study tool and updated the requirements for time studies. The requirement of the number of time studies to be completed per year is changing from at least one full week per six months to at least one full week per quarter. A sample Universal Worker Time Study Template can be obtained by contacting the Department staff listed in this manual.

The time studies must meet the following criteria:

- A minimally acceptable time study must encompass at least one full week per **three month period** of the reporting period.
- The weeks selected should vary among the quarterly time study, e.g. one the first week of the month, one the third week of the month, one the fourth week of the month.
- The time study must not occur in two consecutive months.
- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
- The time study must be facility specific. Thus, chain organizations may not use a time study from one facility to allocate the costs of another facility or a time study of a sample group of facilities to allocate the costs of all facilities within the chain.
- The time study must be individual specific. Thus, one employee's time study cannot be used to allocate the costs of all blended workers performing the same/similar duties.
- Corporate Office staff cannot use time studies to record time worked at nursing facilities. Corporate office staff must use direct identification of time worked through the time record system. For nurse consultants who work out of the central office, see line 6176 for further instructions.

The following are examples of hours that are not to be reported as productive hours:

  - Vacation, holiday, sick leave, classroom training, meeting, and unpaid breaks.
  - Volunteer hours.

0312 - 0315

Report staffing hours for staff that are working at the nursing facility and are employed through a Supplemental Nursing Services Agency (SNSA). The hours for internal pool staff that are on the facility's payroll are NOT to be reported here. The internal pool staff should be reported on the salary cost report lines specific to the licensure or certification of the staff and the duties that the internal pool staff perform.

Report staffing hours for the members of the National Guard and other non-compensated hours related to all natural disasters or peacetime emergency. The hours worked by staff provided via the Minnesota State Emergency Operations Center (SEOC) should be reported here.

Nursing facilities should prepare a reconciliation of hours reported by license/certification. The non-compensated hours should be included in this reconciliation separately from the hours worked at the nursing facility by the SNSA staff.

0316

Report interim nursing administration hours from non-facility personnel here. SNSA hours are NOT to be reported here. Interim nursing administration are licensed nurses responsible for management of the nursing department such as the DON, ADON, infection control nurse and MDS Coordinator.

Nursing facilities should prepare a reconciliation of hours reported by license/certification. The non-compensated hours should be included in this reconciliation separately from the hours worked at the nursing facility.

0320

Record productive hours for Other Care Related Staff on this line. Other Care Related Staff includes any nursing employees who do not fit into Nursing Administration, RN, LPN, C.N.A. or TMA categories. Do not include medical records personnel on line 0320; they are to be reported on line 0321. Include any other staff providing care related services to residents such as paid feeding assistants and religious personnel employed by the facility. Dietary aides, resident companions, dining companions, and support services staff are not to be included. Do not include licensed therapists or their assistants performing separately billable services including Medicare Part A and B or other third-party payor.

Pool Usage Calculation: The Temporary Staff Pool Usage Percentage is calculated by using the total Nursing Pool RN, LPN, C.N.A., TMA hours divided by the total RN, LPN, C.N.A., TMA productive hours and total Nursing Pool RN, LPN, C.N.A., and TMA hours.

Care Related Staff Hours per Resident Day: The following list describes the steps taken to determine the care related staff hours per resident day.

- Resident days include NF days and NFII days (Report lines 5001 to 5100).
- Both regular and pool productive hours are included (Report lines 0301 to 0320).
- Productive hours are converted into Hours per Resident Day figures: RN hours / resident days, LPN hours / resident days, etc.

The following job classifications are considered direct care staff for the purposes of assigning stars on the MN Nursing Home Report Card for the direct care staff hours per day measure only. Hours per Resident Day are weighted for relative cost per staff type (statewide average salary ratios):

Staff Type	Ratio
DON/Nursing Administrator	1.91
RN	1.79
LPN	1.39
C.N.A.	1.00
TMA	1.07
Mental Health Worker	1.32
Social Worker	1.25
Activity Staff	.89
Other Care Related Staff	1.09

- Sum of cost weighted hours =
  (DON hrs paid * DON cost wt) + (RN hrs paid * RN cost wt) + (LPN hrs paid * LPN cost wt) + (C.N.A. hrs paid * C.N.A. cost wt) + (TMA hrs paid * TMA cost wt) + (MH hrs paid * MH cost wt) + (SW hrs paid * SW cost wt) + (ACT hrs paid * ACT cost wt) + (OTH hrs paid * OTH cost wt).
- Sum of cost-weighted hours is adjusted for facility average acuity: Adjusted Hrs paid = (Sum of cost weighted hours) / average acuity.

Compensated Hours

0330 - 0388

Record the hours paid by employee classifications. Paid vacation, sick, holiday hours, etc., should be included. Compensated hours should be equal to or greater than productive hours reported on lines 0301- 0320. Compensated hours must be allocated to care related hours according to the same methodology adopted for allocation of productive hours and salary expense for those employees performing both care related and support services.

To accurately compute average hourly rates, it is important that compensated hours for care related workers are classified in the same category that their associated salaries are reported. For example, if the salary for a Universal worker has been allocated between C.N.A. salaries and support services salary, the compensated hours for the C.N.A. on line 0380 should reflect the same proportion used to allocate the salary. A Universal Worker does not include staff who do not perform any direct resident services.

The reported salary cost per compensated hour calculation for Nursing Administration includes both lines 6111 and 6260.

Other Employee Information

0401 - 0414

Record the total number of employees by employment status as of the last day of this reporting period as either FT (full-time) or PT (part-time). The term “full-time employee” means, an employee who is employed on average at least 30 hours of service per week. Report the number of workers, not by FTEs. Exclude temporary workers, on-call staff, casual workers, and contract workers.

Employee Health Insurance

0601

Indicate whether the nursing facility offered facility employees health insurance, as defined in M.S. 256R.02, during this cost report period.

If the facility selects "Yes" on Line 0601, the following additional Cost Report lines must be completed:

0602

Enter the total number of employees directly employed by the nursing facility that were enrolled in the facility's health insurance plan as of the last day of the report period.

0603

If the facility offered health insurance at any time during this cost report period and if the health insurance plan was self-funded and/or the facility used a captive/related organization for all or part of its health insurance plan indicate "Yes". If self-funded through a Medicare qualified trust plan or captive the facility must submit the plan report and related documentation to DHS by the cost report submission deadline. Your self-funded plan needs to be reviewed and approved by DHS to be considered for reimbursement. If the facility is self-funded for health insurance, other than through a Medicare qualified trust plan or captive, the facility must submit a breakdown of the costs which include claims paid, employee contributions, drug rebates and all other rebates received from the insurance carrier, and administrative fees by the cost report submission deadline.

0604

Indicate "Yes" if at any time during the cost report period, the facility's worker's compensation insurance plan was self-funded and/or the facility used a captive/related organization for all or part of its worker's compensation insurance plan. If self-funded through a Medicare qualified trust plan or captive, the facility must submit the plan report and related documentation, and a breakdown of the costs, which include claims paid and administrative fees, to DHS by the cost report submission deadline. Your self-funded plan needs to be reviewed and approved by DHS to be considered for reimbursement.

Section 6: Costs and Expenses

Unless otherwise indicated, all cost data must be rounded to the nearest whole number (i.e. round .4 down, round .5 up).

Care Related, Support Services, G&A, Payroll Taxes, Payroll & Benefits, and External Fixed Line(s)

General

"Balance per Books" must be recorded using the following principles:

- If the account has a debit balance, record as a positive amount.
- If the account has a credit balance, record as a negative amount.

- "Adjustments" may be positive or negative.

The "Balance per Books" column is to match the facility's income statement figures.

Cost Principles

Costs reported must use the Medicare Cost Reporting Principles. These principles adjust facility balance per books costs to actual cost and do not allow costs that are not directly related to the care of residents to be claimed for computation of the reimbursement rate.

For rate setting purposes, a cost must:

- Be ordinary, necessary, and related to resident care;
- Be what a prudent and cost-conscious businessperson would pay for the specific good or services in the open market in an arm's length transactions;
- Be for goods or services actually provided in the facility; and
- Be recorded on the accrual basis of accounting per Section 256R.09 subdivision 5 except for governmentally owned nursing homes with approval to use cash or a modified cash basis. Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expenses and assets are recorded in the period in which they are incurred, regardless of when they are paid.
- For reimbursement purposes, a provider must pay an accrued nonpayroll expense within 180 days following the end of the cost reporting period. A provider must not report an expense disallowed for nonpayment unless the commissioner grants a specific exception to the 180-day rule for a documented contractual arrangement such as receivership, property tax installment payments, or pension contributions.

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

Reasonable resident-related costs must be determined in accordance with the rate setting procedures set forth in this Instruction Manual and instructions issued by the Department, Minnesota Statutes, and principles of reimbursement for provider costs (Centers for Medicare and Medicaid Services Provider Reimbursement Manual).

The Adjustments column is to be used to:

- Change Balance Per Books amounts to reflect actual expenses incurred such as eliminating profit on related party transactions;
- Change Balance Per Books amounts to reduce costs to recognize public grants;
- Exclude items not recognized by Medicare such as the cost of television, streaming services, and telephones in resident rooms, contributions made, amounts donated to others, cost of political lobbying, personal expenses of owners or employees, costs related to fund raising events, salaries and associated costs of facility marketing, expenses related to changes of ownership of the facility, expenses related to providing special services, and penalties paid to governmental agencies. Items such as these

must be separately reported in General and Administrative costs, line 8085, Other General & Administrative Expense, Medicare Non-Allowable in the balance per books column and removed in the adjustments column.

- Remove non-allowable costs.
- Reclassify costs to the correct line of the cost report.

Explanations of Adjustments Made to the Report are to be entered if adjustments are made to any item on the Cost Report. **Refer to section titled Entering Adjustments on the Cost Report at the beginning of this Instruction Manual for detailed steps of how to enter adjustments into the Nursing Facility Provider Portal.**

Allowable Costs: Costs of the facility directly related to the care of residents which are ordinary and necessary and determined to be acceptable costs during the Cost Report period by the Department in accordance with the rate setting procedures set forth in this Instruction Manual, Minnesota Statutes, and the Centers for Medicare and Medicaid Services Provider Reimbursement Manual. **See Exhibit 1 and Exhibit 2: Cost Classification Table of Potential Allowable Costs on the last few pages of this Instruction Manual for examples of common allowable costs.**

For more information about allowable costs see M.S. Chapter 256R and the CMS Provider Reimbursement Manual.

Non-Allowable Costs: Costs of functions normally paid by charges to residents, employees, visitors, or others such as the direct and indirect costs of operating a pharmacy, congregate dining program, home delivered meals program, gift shop, coffee shop, beauty shop, adult day care, apartments or day care center are non-allowable and must be removed in the adjustments column of the cost report. **See Exhibit 3: Cost Classification Table of Potential Non-Allowable Costs on the last few pages of this Instruction Manual for examples of common non-allowable costs.**

"Applicable Credits" must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost.

- The related expenses must be reported on the appropriate expense line.
- Miscellaneous or other income must be shown as a credit to the related expense.
- Costs associated with expenses not related to resident care must be adjusted on the applicable expense line or total revenue associated with income not related to the nursing facility may be reported as an applicable credit.
- The reported cost of any good or service must be reduced by any amounts returned to the provider by the vendor. Any return or discount by a vendor is an applicable credit under MN 256R.02, Subd. 6. All forms of returns, including rebates, discounts, and direct reduction in invoice amounts, must be included on the cost report as a credit. Vendor credits are not considered donations for reimbursement purposes. Goods or services provided without charge by any party should not be included at an imputed valuation in the cost report per the Medicare PRM Section 2102.4.

"Bonuses" are to be recorded in applicable salary lines.

"Changes in Accrued Vacation/Sick Leave Pay" is the change in amount not utilized by the employee from year to year. It is computed by taking the accrued vacation pay and sick leave balances at the end of the reporting year and deducting the accrued vacation pay and sick leave balance at the end of the prior reporting year. Accrued vacation/sick leave should only be added for the portion of that time that is vested and fully payable to the employee upon termination of employment. Per MN Statute, 256R.02, Subd. 52a "Vested" is defined as meaning the existence of a legally unconditional right to a present or future benefit. If there are any circumstances whereby accrued leave would be forfeited upon termination of employment the leave is not considered vested. In some circumstances a portion of accrued leave is not vested and must be excluded from the accrual. For example, where an employee is not eligible to use or receive pay-out for accrued leave within a certain period from the date of hire that portion is not vested.

Changes in accrued pay cannot be reported in salaries lines (line 6113, 6313, or 8013, for example).
Changes in accrued pay must be reported in the cost report lines that end with "17".

SAMPLE ACCRUED VACATION PAY 9/30/XX

Name	Vacation Hours Balance 9/30/X1	Hourly Wage 10/1/X1	Vacation Accrual 9/30/X1	Vacation Hours Balance 9/30/X2	Hourly Wage 10/1/X2	Vacation Accrual 9/30/X2	Change In Accrued Vacation
A.Tarro	47	7.49	352.03	35	7.74	270.9	(81.13)
J.Nowon	27	9.49	256.23	35	10.10	353.5	97.27
J.Cody	60	8.50	510.00	42	9.00	378.00	(132.00)
L.Folie	34	6.13	208.42	35	6.33	221.55	13.13
T.Baron	19	5.00	95.00	28	7.00	196.00	101.00
O.Dia	5	12.53	62.65	12	13.25	159.00	96.35
Total							94.62

SAMPLE ACCRUED SICK LEAVE PAY 9/30/XX

Name	Sick Hours Balance 9/30/X1	Hourly Wage 10/1/X1	Sick Accrual 9/30/X1	Sick Hours Balance 9/30/X2	Hourly Wage 10/1/X2	Sick Accrual 9/30/X2	Change In Accrued Sick Leave
A.Tarro	35	7.49	262.15	42	7.74	325.08	62.93
J.Nowon	20	9.49	189.80	19	10.10	191.90	2.10
J.Cody	83	8.50	705.50	57	9.00	513.00	(192.50)
L.Folie	45	6.13	275.85	45	6.33	284.85	9.00
T.Baron	24	5.00	120.00	28	7.00	196.00	76.00
O.Dia	8	12.53	100.24	10	13.25	132.50	32.26
Total							(10.21)

Personnel with multiple duties: When a person other than top management personnel has multiple duties, the person's salary cost must be allocated to the cost categories based on time distribution records that show actual time spent, or an accurate estimate of time spent on various activities. An accurate estimate is derived from time studies completed by each employee with multiple duties. These time studies must comply with DHS requirements.

- A nursing facility that chooses to estimate time spent must use a statistically valid method.

- Persons who serve in a dual capacity, including those who have only nominal top management responsibilities, must directly identify their salaries to the appropriate cost categories.
- The salary of any person having more than nominal top management responsibilities must not be allocated.

Employee Union Information

For each salary line, click the "Yes" button if there is a union agreement in place effective on the last day of the reporting year. From the drop-down box, select the bargaining unit that covers the employees whose salaries are reported on that line. This cannot be done until the General Information section is completed.

For staff categories in the facility that are not represented by a collective bargaining unit, select "N/A" rather than "No".

Select "No" for staff categories that are represented by a collective bargaining unit in this facility but for whom there was not a union agreement in place on the last day of this reporting period.

Care Related

6111

Nursing administration includes licensed nursing staff responsible for management of the nursing department or primarily responsible for record keeping. Examples of nursing administration staff include: DON, ADON, MDS coordinator, Medicare nurse, infection control nurses and quality coordinators. Staff in this category are primarily performing job duties where a **nursing license is required.** Interim nursing administration provided by non-employees are not to be reported on this line. See Line 6150 for interim nursing administration costs for people that are not an employee of the nursing facility.

6116

Medical Records staff that are primarily responsible for record keeping or other administrative duties within the nursing department are to be reported on this line. Examples include unit coordinators, schedulers, medical records staff; duties for which a nursing license is not required, etc. The title "unit coordinator" or "schedulers" used as examples does not indicate job title is the sole requirement for inclusion on line 6116. Time studies based on DHS requirements, or a position description may be requested by the Department and reviewed for allowability on line 6116. Any care related employee, regardless of their title, that is providing services to support departments shall have those duties assigned to the support department. Central Supply duties and general facility administrative duties not directly related to medical records or nursing staffing performed by Medical Records, Unit Coordinators, or Scheduling staff should have those duties allocated to Line 8013 – Administrative Salaries. **Please note the difference between line 6111 and line 6116 with regards to licensure.**

6150

Interim Nursing Administration includes interim staff and/or consultants who are hired on an interim basis, have an active MN or bordering state nursing license, are contracted to conduct nursing administration duties, and, they are NOT an employee of the nursing facility or the corporate office. These positions include, but are not limited to, Director of Nursing, Assistant Director of Nursing, and MDS staff. Minnesota is not a member of the nurse license compact, but does have border state recognition with North Dakota, South Dakota, Iowa, or

Wisconsin. For border nurses to work in MN, the nurse cannot have disciplinary sanctions on the license in the bordering state. The border state recognition does not extend to nurses working at a temp agency without a MN license. Interim nursing administration staff hours are not subject to the maximum charges provision in Minnesota Statute 144A.74 Maximum Charges.

6151 - 6154

Nursing Pool Salaries include the wages of RN, LPN, CNA, and TMA for staff who are utilized through a Supplemental Nursing Services Agency (SNSA). Employees of therapy companies performing non-billable therapy services are NOT to be reported here. Staff utilized through a SNSA are subject to Minnesota Statute 144A.74 Maximum Charges. The maximum charges for Holiday's apply to state holidays only. The state recognized holiday's include New Year's Day, Martin Luther King's Birthday, Washington's and Lincoln's Birthday, Memorial Day, Juneteenth, Independence Day, Labor Day, Indigenous People Day, Veterans Day, Thanksgiving Day, and Christmas Day. Late fees charged by a SNSA agency for late payment of invoices is not an allowable cost on the Cost Report.

Fees charged by a SNSA agency for hours not worked or late cancellation charges are not an allowable cost on the cost report. These hours and late cancellations are considered a penalty and not considered reasonable, ordinary or what a cost-conscious or prudent buyer would pay.

DON's and MDS Coordinator wages who are hired as interim staff and/or consultants should be reported on Line 6150.

Minnesota Statute 144A.74 Maximum Charges was updated to include **actual** travel and lodging costs for SNSA staff employed by a Minnesota-registered supplemental nursing services agency who work at the facility. Nursing facilities may pay the actual cost of travel and housing for SNSA staff to the employee, the agency, or another vendor without violating the limitation of maximum allowable charges under statute. SNSA travel and housing costs are allowable on Line 8080 and the costs need to be adjusted off Line 6151 – Line 6154. A "per diem" charge is not an allowable expense on the cost report as these costs do not reflect the actual costs related to travel and housing.

DHS requires the following documentation submission for Lines 6151-6154: Provide a detailed schedule for the hours and costs reported on this line. The detailed schedule should include the date, hours, amount paid, vendor name, and the description/type of expenditure by staff licensure. Hours worked by non-compensated staff (i.e. National Guard, SEOC, etc.) should be included by licensure of the staff in this reconciliation schedule separately from the SNSA staff. Provide supporting documentation for adjustments that are made to remove costs over the maximum allowable MDH rate. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6212

Activities staff salaries includes the wages of the supervisor and other activities workers such as volunteer coordinators and recreation aides.

6213

Other Care Related Staff includes staff providing care related services to residents who are not appropriately categorized on lines 6111 through 6212. Generally, employee salaries should be classified according to their

certification or licensure category regardless of their job title. Examples of Other Care Related Staff include paid feeding assistants, religious personnel, and non-licensed and non-certified therapy aides. Dietary aides that have not completed the Minnesota approved training course for feeding assistants, dining room companions, resident companions, and support services staff are not to be included. Other Care Related Staff does not include licensed therapists or therapy assistants providing services for billable therapies, including Medicare Part A and B.

6260

Record the wages of the employee in charge of conducting training in resident care topics for care related staff. Typically, this will be the in-service director. If facility staff provides the nursing assistant classes at the nursing facility, the wages associated with the time spent conducting the class and competency evaluation, **must** be classified as scholarship costs on line 7017 instead of line 6260. The wages associated with the facility staff who conducted the training should be split amongst the number of students that took the training at the nursing facility during the cost report year and reported as tuition costs on line 7017. **For additional instructions to report scholarship costs, refer to the section titled NF Employee Scholarship Program near the end of this instruction manual.**

6261

Report non-wage related costs of training direct care related staff on this line. The costs of materials used for resident care training for direct care staff and training courses outside of the facility attended by direct care staff on resident care topics are to be reported on this line. Direct Care staff include those staff defined as Nursing Administration, RN, LPN, CNA, and TMA that are employed directly by the nursing facility. Other staff in positions such as Social Workers, Activities, Medical Records, Mental Health, or Other Care-Related positions should have all of the training costs reported on Line 8080-General & Administrative. Costs for nursing assistant training and testing must be reported on line 7017 (Scholarship Costs) instead of line 6261. The employee scholarship program cannot provide reimbursement for nursing assistant training for newly hired nurse aides that have completed the coursework and clinical training prior to being hired at the nursing facility if the nurse aide received reimbursement for these costs through a previous employer.

Costs related to the Nurse Aide Registry In-Facility Testing program are required to be offset by all grant funds received.

Costs for meals, lodging, and travel related to training costs must be reported on line 8080 (General & Administrative) no matter the licensure of the staff. Travel related to training is not an allowable cost on line 7017 (Scholarship Costs).

Costs for staff time spent to complete annual education or time at an annual skills fair should be reported on the related cost report line for the employee's salary classification and not reported on Line 6260 or Line 6261.

For eligible scholarship expenses, refer to the section titled NF Employee Scholarship Program near the end of this instruction manual.

DHS requires the following documentation submission for Line 6261: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the NF Provider Portal for

additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6120

Nursing Supplies & Non-prescription drugs includes supplies that are stocked at nursing stations or on the floor and distributed or used individually, such as rubbing alcohol or alcohol swabs, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, personal hygiene soap, medication cups, diapers, sanitary products, disposable thermometers, hypodermic needles and syringes, and medically necessary over the counter (OTC) medication and supplies used on an occasional or as needed basis (also known as "House Stock") that are not payable on a separate fee schedule by the medical assistance program or any other payer. Nutritional supplements and tube feedings are not to be reported on this line; they must be reported on Line 6330 – Raw Food.

Medical supplies purchased and delivered to a central location for disbursement to multiple nursing facilities and non-nursing facilities must be assigned directly based on the actual cost and the actual usage of medical supplies by each facility. The Department may request disbursement records to support the allocation of costs. The disbursement records must include the name of the facility receiving the product, the quantity received, and the actual cost of the product.

The information related to Prescription Drugs and Over-the-Counter (OTC) medication or supplies is based on current regulations (state and federal) and is subject to change. The information below does not include all the reasons as to why prescription and some OTCs are not allowable as the topic is very broad and complex.

Prescription Drugs

Generally, prescription drug costs for nursing facility residents are not allowable on the MN Medicaid Cost Report because there are almost always other avenues for which prescription drugs can and should be covered.

The resident's pharmacy benefit plan is the primary source for coverage of prescription drugs. Examples of pharmacy benefit plans include Medicare Part B, Medicare Part D, Minnesota Health Care Programs (MHCP aka as MN Medical Assistance), etc. The pharmacy costs for residents on a Medicare Part A stay are all-inclusive in the Medicare Part A per diem and are not allowable on the cost report. All pharmacy benefit plans have a drug formulary (a list of covered drugs) and most (if not all) have at least two different drug options for every classification of drugs. If the doctor prescribes something non-formulary for a nursing facility resident, he/she/they should be asked if they would be willing to change the prescription to a formulary alternative. If the prescriber is unwilling to change to a formulary alternative, then there are two more options to getting this prescription paid for separately (separately meaning that it is paid for outside of the nursing facility daily rate).

a. The prescriber should submit a prior authorization request for non-covered/non-formulary prescription drugs. Every pharmacy benefit program has a form and process for requesting coverage of a non-formulary prescription drug. Some prescription plans allow the pharmacist to request a prior authorization. There is a means for the pharmacy to dispense and get paid from the pharmacy benefit program for a temporary immediate supply if the pharmacy needs to wait for their prior authorization request to be reviewed. If a prior authorization request is denied there is another option:

b. "Prescription drugs are part of the pharmaceutical services that facilities are required to provide. However, at times, a resident needs a medical service that is recognized by State law, but not covered by the State plan. Such a medical service includes a prescription drug that is not on the State's formulary or that

exceeds the number of medications covered by Medicaid. It may also include prescription eyeglasses or dentures. If a resident needs a recognized medical service over what is allowed by the State plan, the resident has the right under the Medicaid statute to spend his/her/their income on that service. If the service is more than what Medicaid pays, the resident may deduct the actual cost of the service from the Medicaid share of the cost. The facility must assist the resident in exercising his/her/their right to the uncovered medical expense deduction and may not charge the resident for such services." Source: State Operations Manual, Appendix PP. Typically, what will happen is that the Nursing Facility and recipient will work with their county worker to reduce their spenddown for the month in which the expense occurred to help cover the cost. The MA-LTC recipient or AREP contacts the county worker; the worker will verify the amount of the medical expense not covered by MA that was paid by the recipient. The worker will then decrease the spenddown amount for the month that the expense was incurred. There are forms used to effectuate this process.

Some of the other reasons that we see prescriptions on the cost report that are not allowable:

- "Patient is not covered" sometimes means the recipient's Medical Assistance application is pending therefore their prescriptions deny. The pharmacy can re-process these denied claims at a later date after the Medical Assistance application is approved. It is the nursing facility's responsibility to inform the pharmacy when the recipient has been approved for Medical Assistance; the pharmacy has no way of knowing this. "Patient not covered" could refer to non-Medicaid recipients as well, and in that case the pharmacy may not have the right/current prescription benefit information, or, the resident doesn't have any prescription drug coverage. If a resident does not have prescription drug coverage via a pharmacy benefit plan (or Part B or Part D) the resident will need to pay privately for their prescriptions.

- Resident is between health plans. The Drug Prior Authorization form can be used for this so that the prescription can be paid for via a pharmacy benefit.

- Prescription denied as a "refill too soon." If this happens because the nursing facility lost the resident's medication, then this is a nursing facility cost that is not allowable on the cost report. Sometimes this is seen when people first move into a nursing facility and the County has not updated the eligibility or resident's living arrangement. In these cases, the pharmacy can re-process claims at a later date, after the County has updated the living arrangement in our system from "Community" to "Nursing Facility/Institution". It is the nursing facility's responsibility to inform the pharmacy that the living arrangement has been updated by the County and should advise the pharmacy to re-run those Rx claims.

- They would have been coverable by Part B if Part B had been billed correctly and timely (assuming the resident had Part B and it was a Part B covered item).

- It is for a resident covered by a Medicare Part A stay.

- It is for a prescription taken out of an E-Kit and used for a specific resident.

A nursing facility may choose to pay for a prescription drug for a resident but that does not automatically make it an allowable cost on the cost report. If a nursing facility claims the cost of prescription drugs of residents on the cost report, they will need to provide an explanation and documentation to demonstrate that it is an allowable cost. Stating "non-covered by the health plan" is not sufficient documentation.

Over the counter (OTC) medication and supplies

The following is an excerpt from the Minnesota Health Care Programs (MHCP) manual:

The OTC medication and supplies that are for occasional or as needed use (usually written as "PRN") are part of the nursing home's daily rate, never has a resident's name on the package/label, are almost always kept in stock in the facility and ordered in bulk and are thus allowable costs on our cost report. House stock items, such as Prevnar, Flu vaccines, COVID-19 vaccines, drugs in e-Kits, Energix-B are not allowable on the cost report as these drugs are considered separately billable and covered by pharmacy benefit plans. Costs for Mantoux tests, generally Aplisol and Tubersol, are allowable on Line 6120 for residents only. Costs for Mantoux tests for staff should be reported on Line 9080-Other Employee Benefits.

Over the counter medication and supplies prescribed and dispensed and labeled for a specific resident for scheduled use (for example, take one pill twice daily) should be dispensed in the manufacturer's unopened package and submitted separately to pharmacy benefit (e.g. MHCP/Medical Assistance) for reimbursement. These OTC costs are not allowable on our cost report.

Here is an example to help differentiate when the cost of an OTC is the nursing facility's responsibility (thus allowable on the cost report):

Senna is an OTC medication. If Senna is prescribed to a resident to take "as needed for occasional constipation" the nursing facility should provide this to the resident from this house stock and the pharmacy is supposed to bill the nursing facility for the Senna bulk bottle/house stock. This house stock of Senna is then available for every resident that has an MD order to take a stool softener PRN (as needed). Note here that this is a bulk purchase of Senna from the pharmacy that does not have a specific person's name and that the order is on an as-needed basis only.

If a resident needs Senna twice a day every day ("scheduled use"), then the pharmacy should NOT bill the nursing facility for the Senna. The pharmacy should dispense the Senna in the manufacturer's unopened package and submit the charge for this to Medical Assistance (or the appropriate payor) for reimbursement.

Like prescription drugs, pharmacy benefit plans have a "formulary" (aka preferred drug lists) that list the OTCs that they cover.

Office supplies are not to be reported on this line; these are an administrative cost. However, pre-printed physician telephone order forms that can only be used by licensed health care staff should be reported on this line.

Minor equipment that is purchased by the facility is not to be reported on this line; these are a maintenance cost and is to be reported on Line 6680. Minor equipment that is rented by the facility is not to be reported on this line; these are rental equipment costs and is to be reported on Line 7053. Minor equipment that is purchased or rented for a specific resident is not an allowable cost on the cost report if the cost is considered separately billable or reimbursable from other payor sources.

Costs that are incurred due to the use of vendors that supply products or provide services that are considered separately billable/reimbursable from other payor sources who are not enrolled as a MN Medicaid provider are not allowable.

COVID-19 testing costs for residents generally will not be allowable on the cost report as these testing costs are covered by other payor sources. Labs and nursing facility providers with the CLIA waiver can bill for the resident's COVID-19 tests through the resident's insurance and the nursing facility is obligated to provide the insurance information of the residents to the labs. There are state and federal programs to cover COVID-19 testing costs for the uninsured.

DHS requires the following documentation submission for Line 6120: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. Nursing facilities must submit the Supplier Distribution Report (i.e. McKesson, Elim Preferred Services, TwinMedical, GeriMedix, Medline, etc.) for the main supplier of nursing supplies reported on Line 6120 for the time period identified on the first page of this document. The Department may request additional supply distribution reports upon review of the general ledger detail submitted. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6140

All prescription drugs paid for by the facility are to be recorded on this line. Prescription drugs are generally not considered an allowable cost because they are almost always covered by or billable to other payor sources.

The Nursing Facility Related Costs column for this line of the Cost Report should typically be zero.

- Non-formulary drugs are not an allowable cost because there are other formulary alternatives available, and, there is a prior-authorization process available for getting these drugs covered through the prescription benefit.
- "Refill too soon" prescription drugs are generally non-allowable as they are often due to the drugs being lost in the facility.
- "Insurance information incorrect" prescriptions drugs are generally non-allowable as they are often due to the facility not providing the correct insurance information to the pharmacy.
- "Patient is not covered" sometimes means the recipient's Medical Assistance application is pending therefore their prescriptions deny. The pharmacy can re-process these denied claims at a later date after the Medical Assistance application is approved. The resident's pharmacy benefit plan is the primary source for coverage of prescription drugs. All pharmacy benefit plans have a drug formulary (a list of covered drugs) and most (if not all) have at least two different drug options for every classification of drugs. If the doctor prescribes a non-formulary drug for a nursing facility resident, the prescriber should be asked if they would be willing to change the prescription to a formulary alternative. The prescriber should submit a prior authorization request for non-covered/non-formulary prescription drugs. Every pharmacy benefit program has a form and process for requesting coverage of a non-formulary prescription drug.

A nursing facility may choose to pay for a prescription drug or over-the counter medication for a specific resident but that does not automatically make it an allowable cost on the cost report. If a nursing facility claims the cost of prescription drugs or over-the-counter medications for a specific resident on the cost report the nursing facility will need to provide an explanation and documentation to determine that it is an allowable cost.

Costs that are incurred due to the use of pharmacy vendors who are not enrolled as a MN Medicaid provider are not allowable.

Prescription drugs and other separately billable supplies and services for residents on Emergency Medical Assistance (EMA) are not allowable costs because these can be paid for separately when an approved Care Plan Certification and/or Prior Authorization is in place. For more information on the topic of EMA see this webpage: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008925#cpc.

6220

"Activity and Social Service Supplies" should include both supplies and services associated with the Activities and Social Services Department. Examples may include: cable television and streaming service (e.g. Hulu, Netflix, etc.) in common areas of the nursing facility, pet care and pet supplies, piano tuning service, art programs, entertainers/musician/dance/theatric performances at the facility, Pastoral Care stipends and supplies, and bus rental for resident outing activities. Costs related to shared resident and staff activities, such as Nursing Home Week, must be allocated between Line 6220 and Line 8080. Any type of gifts given to the resident and/or resident's family are not an allowable cost on the cost report. Flowers or vegetables planted by the residents as part of an activities program are allowable. Landscaping including plants, trees, shrubs, garden tools, and lawn and garden care products should be reported on line 6680. The reasonable costs of supplies for ADL-related activities such as manicures, hair styling and makeovers provided by facility staff that are not licensed beautician/barber may be considered part of the activities program, thus allowable.

Costs for hair salon billable services and supplies that are beyond basic services, such as permanent waves, hair coloring, and hair relaxing are chargeable to the resident, thus not allowable and need to be removed in the Adjustment column of this line. Nursing facilities that choose to not charge for billable salon services will need to remove all billable salon services in the Adjustment column of this line as the costs will be considered not allowable.

Costs for meals, lodging, volunteer and/or staff recognition, and mileage are not to be reported here. These costs should be reported on Line 8080.

DHS requires the following documentation submission for Line 6220: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6176

"Health Care Consultants" includes utilization review, pharmacy, in-service, physician fees, licensed nursing, infection control, medical director, dental director, psychology, psychiatry, and other consultants and physical, occupational, speech and mental health consultants. Interim nursing administration by person(s) with an active MN nursing license or border state nursing license should be reported on Line 6150. **Do not** include consultant costs for medical records, social services, or religious consulting (e.g. pastoral care services) on this line.

Therapy consultants doing nurse's in-service training may be reported on this line. Consulting fees for therapy shall only be reported as nursing facility related costs to the extent that the nursing facility or the nursing facility's contractor cannot bill separately for these services. Therapy department staff and licensed therapists attending care conferences are part of the separately billable service and are not an allowable cost on the cost report.

Nurse consultant's costs for those who work out of the central office may be reported here in accordance with MN Statute 256R.02, Subd. 17. Per MN Statute 256R.02, Subd. 17, the salaries and payroll taxes of the corporate nurse consultants must be allocated proportionately by total resident days or by direct identification to the nursing facilities served by those consultants. Time studies are not allowed as these are considered a

statistical surrogate and not a direct assignment of cost. If the corporate nurse consultants provide services to non-nursing home facilities, their time must be directly identified to those facilities or the non-nursing home resident days must be included in the total resident days. Costs reported on this line must be for the state (DHS) cost report period regardless of the central office fiscal year end.

DHS requires the following documentation submission for Line 6176: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6179

"Other Care Related Consultants" include medical records, social services, activities, and religious consulting. Interpreter services provided by non-nursing facility staff are also to be reported on this line. Social Workers or Medical Records personnel who are hired as interim staff from an outside agency should be reported on Line 6179. Costs related to nursing facility entertainment for residents should be reported on Line 6220. Entertainment for staff related activities should be reported on Line 8080.

DHS requires the following documentation submission for Line 6179: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6180

Line 6180 should only contain the costs for the electronic charting systems/Electronic Medical Records (EMR)/Electronic Health Records (EHR) *software* costs which meet the following criteria:

- Not required to be capitalized
- Not already claimed under the Medicare/Medicaid EHR Incentive Program.
- Facilities should report the billing and resident trust component of software costs on Line 8080.
- See **Exhibit 1: Cost Classification Table of Potential Allowable Costs** at the end of this manual for further information on how to correctly report software costs on the Cost Report.
- Cost classification percentages that are split between cost reporting lines will be reviewed annually. The percentages are subject to change based on the annual review.

DHS requires the following documentation submission for Line 6180: Provide a detailed schedule for the amount reported on this line. The detailed schedule should include the date, amount paid, vendor name, and the description/type of expenditure. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6240

All therapy salaries are reported on this line. Therapy salaries include licensed therapists and assistant therapists working under their supervision performing billable therapy, including Medicare Part A and B or any

other third-party payor. Generally, these services are separately billable thus not allowable on the Cost Report; costs associated with billable services should be removed in the adjustment column regardless of whether they were actually billed out.

Minnesota Statute 256R.12 requires that the cost of therapy staff be directly identified. Direct identification includes timecards, schedules, and position descriptions. Directly assigned therapy staff generally will have a therapy licensure and may not be allocated to other departments. The therapy department supervisor, if a separate position, should be directly assigned to the therapy department. Staff that have separate non-therapy positions in addition to therapy positions will have timecards, schedules, and non-therapy position description, and will be directly costed to that department. Position descriptions requiring therapy licensure must be assigned to the therapy department. Direct assignment cannot be based on estimates or time studies. Complete contemporary time records, schedules and job descriptions must exist for any therapy staff with a position outside the therapy department.

Position descriptions must be in effect and retained by the facility during the cost report period to document the cost information reported on the Cost Report in accordance with M.S. 256R.07. Position descriptions created after the cost report period do not meet the document retention requirements of M.S. 256R.07. To consider an employee's position description or any other information created after the end of the cost report period would circumvent this statutory requirement to maintain adequate documentation supporting a facility's cost on the Cost Report.

Minnesota Statute 256R.10 requires costs be ordinary and necessary and that costs are not in excess of what is required. The position of the Department is that the practice of paying licensed therapists or certified therapy assistants to perform job duties that do not require this licensure nor certification (that is primarily what they would be doing if they cannot bill for their time) is not reflective of a prudent buyer. It is not prudent to pay licensed therapists to perform restorative nursing duties when the RAI manual indicates that nursing assistants can perform these duties under the supervision of a licensed nurse. It is also not prudent to pay for licensed therapy staff to perform non necessary tasks such as attending care conferences for residents not receiving therapy services (care conferences for residents receiving therapy is a billable service).

The Department will consider licensed therapy staff providing some in-service training to direct care staff on patient related topics as ordinary non-billable therapy salary costs if the facility has adequate, readily available documentation that shows when the training was conducted (date and time and duration), what type of care-related topic was covered, the names and job titles of the facility staff that attended the training, and the name and title of the trainer. These costs would be quite minimal on an annual basis.

Excerpts from the CMS RAI Manual:

The following criteria for restorative nursing programs must be met in order to code O0500:

- Measurable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.

- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order.
- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A, **Occupational Therapy** item O0400B, and **Physical Therapy** O0400C.

Restorative aides do not require a therapy license nor therapy certificate. The salary of restorative aides is includable in direct care assuming all other requirements are met (e.g. signed and dated job description, rate of pay is reasonable and ordinary, etc.)

6274

Payments to therapists who are not employees of the nursing facility are reported here. Facilities which bill separately for therapy services or whose contractor bills separately for therapy services shall remove the costs of those services in the "adjustments" column.

6280

Line 6280 is for all other care-related expenses not specified elsewhere on the cost report. Ancillary services (excluding therapy and pharmacy) are reported on this line with all costs adjusted off for those that are separately billable (e.g. Medicare Part A lab, x-ray, and wound vac).

DHS requires the following documentation submission for Line 6280: Facilities with costs on line 6280 of this Cost Report form in the "Nursing Facility Related Costs" column are required to complete a detailed schedule of these costs. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6290

Report only care-related applicable credits on line 6290 that cannot/should not be reported in the more specific cost category line of the Cost Report form. Miscellaneous or other income must be shown as a credit to the related expense. For example, purchase discounts or refunds for stock nursing supplies are applicable credits and must be reported on line 6120 to offset the related stock nursing supply costs.

Support Services

General

The salary expense of working in more than one department must be allocated between the applicable cost categories.

NOTE: If you are not a hospital-attached facility, all lines ending in "95" should be left blank, for example 6495.

Dietary

The table below for Dietary Costs and Number of Meals served is in the Assets, Leases, and Debt section of the Cost Report. Enter the number of meals served and the associated income for your facility as shown below into the Nursing Facility Provider Portal:

Line	MEALS SERVED	Number of Meals	Dietary Income	Total Dietary Cost
6341	Residents of this facility	0	0	0
6342	Guest Meals	0	0	0
6343	Meals on Wheels	0	0	0
6344	Employees	0	0	0
6345	Assisted Living	0	0	0
6346	Hospital	0	0	0
6347	Other	0	0	0
6340	**Total**	**0**	**0**	**0**

Dietary meal counts are not to be weighted for allocation basis. "Snacks" would not be included in the dietary meal counts. Dietary meals count for residents should equal no more than three meals per resident day.

"Balance per Books" column for dietary costs must equal the total costs for all dietary operations, which may include costs for non-nursing facility operations (Assisted Living, Adult Day Care, Meals on Wheels, etc.) The Total Dietary Cost column should be calculated using the Total Dietary Costs / Total Dietary Meals utilizing the dietary allocation template included in the Supplemental Schedule.

If the provider has allocated costs to non-nursing facility operations during the report year, these costs will need to be added back to properly allocate total dietary costs based on total number of meals served by the kitchen.

Dietary costs must be reported based on the total dietary costs and total number of meals served including unpaid meals. Allocated dietary costs are required to be based on the meal counts; the applicable portion of dietary costs for non-resident meals served must be adjusted off the Cost Report in the Adjustments column of Lines 6313 to 6380. Any revenue reported on Line 6390 for non-resident meals should be removed.

A dietary allocation template has been included in Tab A of the Supplemental Schedule. Facilities may utilize this template in calculating the dietary costs adjustments for non-resident meals. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

6313

"Dietary salaries" includes the director, dietician, other dietary salaries, and bonuses.

6330

Raw food costs mean the cost of food provided to nursing facility residents. This includes food thickener and special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet. Special dietary supplements also include meal replacement products such as Ensure, Glucerna and Promote.

Medically prescribed dietary supplements may be allowable if the following were met: must have been ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, and the dietary supplements are not considered separately billable. For the cost to be allowable on the Cost Report, there must have been an order on file for a specific resident. Not all dietary supplements are allowable. To be considered for allowability the dietary supplement must be classified as a dietary supplement by the FDA.

A nursing facility that uses contracted dietary services must have the vendor breakout the raw food from all other services; raw food must be reported on line 6330. The cost of the raw food must be supported by invoices for the actual cost of the food. The invoices must be made available upon request to the Department to support the costs of raw food.

Hospital-attached facilities must break this expense out from line 6395 or the NF Provider Portal system edits will prohibit the cost report from being submitted.

6380

Other dietary expenses include contracted food service (excluding food), supplies, and dietician consulting fees. Dietary training and travel are to be reported on line 8080. Office supplies used in the dietary department are **not** to be reported on this line; these are an administrative cost.

A nursing facility that uses a contracted dietary service must have the vendor breakout the raw food from all other services; raw food must be reported on line 6330. The cost of the raw food must be supported by invoices for the actual cost of the food. The invoices must be made available upon request to the Department to support the costs of raw food.

Minor equipment that is purchased by the facility is not to be reported on this line; these are a maintenance cost and is to be reported on Line 6680. Minor equipment that is rented by the facility is not to be reported on this line; these are considered to be rental equipment costs and is to be reported on Line 7053.

6390

Income from operations not related to resident care for which the facility does not track the number of meals served, such as vending machine or snack shop sales should be reported on this line.

All other revenues for operations not related to resident care including employee/guest meals, day care meals, meals on wheels, Assisted Living meals, etc. should be removed from this line and the applicable costs be adjusted off based on the number of meals served.

Laundry and Linen Services

6413

Laundry salaries include the department head, other laundry and linen personnel, and bonuses.

6480

Other laundry and linen include supplies, linen, bedding, and purchased laundry services. Office supplies are not to be reported on this line; these are an administrative cost.

If purchased laundry services are included in the cost of contracted housekeeping; the costs must be broken out and reported here.

Minor equipment that is purchased by the facility is not to be reported on this line; these are a maintenance cost and is to be reported on Line 6680. Minor equipment that is rented by the facility is not to be reported on this line; these are rental equipment costs and is to be reported on Line 7053.

Housekeeping Services

6513

Housekeeping salaries include housekeeping director, other housekeeping personnel, and bonuses.

6580

Other housekeeping includes housekeeping specific supplies and contracted housekeeping. Office supplies are not to be reported on this line; these are an administrative cost.

If purchased laundry services are included in the cost of contracted housekeeping; the costs must be broken out and reported on line 6480.

Minor equipment that is purchased by the facility is not to be reported on this line; these are a maintenance cost and is to be reported on Line 6680. Minor equipment that is rented by the facility is not to be reported on this line; these are rental equipment costs and is to be reported on Line 7053.

Plant Operations & Maintenance

6613

Plant operations salaries include the maintenance chief, other maintenance personnel, and bonuses. If the maintenance personnel provide services to non-nursing facility operations, an allocation of salaries is required. The correct basis for allocation is square footage.

6630

Utilities include fuel, electricity, water, and sewer. Bottled water purchased for use in water systems should be reported on Line 6680.

6680

Other maintenance expenses include supplies, repair parts, minor equipment not requiring capitalization under Medicare guidelines, maintenance and service contracts, plastic waste bags/can liners, purchased services and medical waste and garbage removal. Landscaping including plants, trees, shrubs, garden tools, and lawn and garden care products should be reported on line 6680.

All minor equipment which is not required to be capitalized must be reported on Line 6680. Examples of minor equipment are bedpans, kitchen utensils, cleaning utensils, batteries for medical equipment, reusable slings for patient lifts, and waste baskets. Minor equipment that must be capitalized per Generally Accepted Accounting Principles (GAAP) should be reported on line 1366, Assets Section.

General & Administrative

8013

Administrative salaries include the wages and bonuses for the administrator, assistant administrator, business office, accounting, data processing, clerical, receptionist, inventory and purchasing/central supply and security staff. If the administrative personnel provide services to non-nursing facility operations, an allocation of salaries is required.

8048

Record the cost of professional liability insurance only. Automobile insurance is not to be reported on this line; it is to be reported on line 8080.

8049

Record the cost of property insurance only. The following table provides classification of insurance costs.

CLASSIFICATION OF INSURANCE COSTS

Expense	Cost Category	Line Number
Administrative Prof. Liability	G & A	8048
Automobile	G & A	8080
Board of Directors	G & A	8080
Building	G & A	8049
Building Contents	G & A	8049
Business Income	G & A	8080
Crime Coverage	G & A	8080
Dental (Group)	Fringe Benefits	9025
Disability	Fringe Benefits	9023
Extra Expense	G & A	8080
Flood	G & A	8049
General Liability	G & A	8080
HSA/HRA	External Fixed	9021
Individual Coverage Health Reimbursement Accounts (ICHRA)	External Fixed	9021
Inland Marine	G & A	8049
Loss of Earnings	G & A	8080
Life (Group)	Fringe Benefits	9023
Medical (Group)	External Fixed	9022

Expense	Cost Category	Line Number
MN Fire Surcharge	G & A	8049
Mortgage	Interest Expense	7031
Property of Others	G & A	8080
Umbrella	G & A	8080
Workers Comp	Fringe Benefits	9024
Vision (Group)	Fringe Benefits	9023
Other	G & A	8080

8052

Record the costs of bad debt on this line. The amount reported in the "Balance per Books" column should tie to your reporting year trial balance. The amount reflected in the "Nursing Facility Related Costs" column most likely will NOT tie to your trial balance. The only bad debt that may be considered allowable bad debt on the MN Medicaid Cost Report is bad debt associated with Medicaid covered services for Medicaid recipients while they were covered by MN Medicaid. Any bad debt collected from Medicare during the report year should be entered as an adjustment in the adjustment column. Unpaid claims denied by Medicaid and Medicaid claims that have been written off are not allowable. Bad debt that is non-allowable per Medicare guidelines and/or has been disallowed by the Medicare Administrative Contractor (formerly Fiscal Intermediary) is not allowable. Medicare co-insurance deductibles are not allowable on this cost report. Bad debt related to Hospice is not allowable. Do not include the costs of bad debt collection expense on this line; this should be reported on line 8080.

Use the Bad Debt Section of the Cost Report form to provide a detailed schedule of the allowable bad debt amount being claimed in the Nursing Facility (NF) Related Costs column of line 8052. **Be prepared to provide records of the facility's bad debt collections efforts to DHS immediately upon request.** Incomplete, inaccurate, and illegible collections records may result in disallowances of costs. The NF Related Costs column should only include the amount of the unpaid recipient resource amount.

8073

Record central office costs and management fees directly related to the operation of the nursing facility on this line. The central office costs recorded on the Cost Report may be for the central office's fiscal year if different from the Cost Report period. However, the fiscal year must be the year closest to the Cost Report period. Central office costs should be allocated to the nursing facility according to Medicare cost reporting principles.

8080

Other general and administrative expenses include: fees, contracts, or purchases related to the business office functions; Administrator's license fee, most other license fees (exceptions: EMR clinical software Line 6180 and MDH license fees Line 7015), permits, employee recognition, travel including meals and lodging, all training (except as provided in direct-care and scholarship costs categories), voice and data communication or transmission, all office supplies regardless of what department is using them, property/liability insurance and other forms of insurance (see Classification of Insurance Costs under line 8049 in this instruction manual), personnel recruitment, accounting services, management or business consultants, data processing, information technology, web-site, business meetings and seminars, postage, fees for professional organizations,

subscriptions, security services, allowable advertising (e.g. yellow pages), nonpromotional advertising, board of directors fees, working capital interest expense, actual costs incurred for travel and lodging for persons employed by a Minnesota-registered supplemental nursing services agency, and bad debt collection fees (but not the actual bad debt). Bad debt expense should be reported on line 8052.

Credit card fees must be reported on this line. Per the Provider Reimbursement Manual, "Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs. Credit card charges incurred by a provider of services represent costs incurred for prompt collection of accounts receivable. These charges (if reasonable) may be recognized as a substitute for the costs that would otherwise be incurred for credit administration (e.g. credit investigation and collection costs)." Providers are not permitted to charge residents a fee for using a credit card since it is included in the per diem.

Refer to Exhibit 1 and Exhibit 2: Cost Classification Table of Potential Allowable Costs which provides a list of common expenses which should be categorized in general & administrative expense.

8085

Items not recognized by Medicare such as the cost of telephones or cable television or streaming services in resident rooms, contributions made, amounts donated to others, cost of political lobbying, personal expenses of owners or employees, costs related to fund raising events, expenses related to changes of ownership of the facility, expenses related to providing special services, promotional materials/advertising and marketing, and penalties paid to governmental agencies (including Civil Monetary Penalties) should be separately reported on this line. The amount reported on this line should be removed from allowable nursing home costs by entering a negative amount in the adjustments column.

Refer to Exhibit 3: Cost Classification Table of Potential Non-Allowable Costs which provides a list of common expenses which should be categorized here.

Payroll Taxes and Fringe Benefits

9011 - 9026

This section of the Cost Report must be completed except for line 9017.

- **Changes in Accrued Vacation/Sick Leave Pay may be reported in each individual cost category on the lines ending with "17" for all employees in the nursing facility if the Changes in Accrued Vacation/Sick Leave Pay is considered vested.**
- The information on lines 9100 to 9280 may be completed in addition to this section to directly allocate the costs by cost category.
- Central office fringe benefits cannot be included on this page.
  Adjustments to offset payroll taxes and fringe benefits allocated to non-reimbursable areas or other operations should be made to the appropriate payroll tax or benefit line. At the request of the Department, the provider must submit detail of these adjustments and how the amounts to offset were calculated.

9023

"Other Employee Insurance" includes vision insurance, disability insurance and group life insurance. The employee deductions withheld for "Other Employee Insurance" should offset the employer portion of the insurance.

9024

Report Worker's Compensation expense for the reporting period.

If the plan is **not** self-insured, the nursing facility is required to:

- Submit the Worker's Compensation audit(s) received during the cost reporting period.
- If the premiums are shared with other providers, provide the total costs and allocation to each facility as well as the allocation basis.
- Provide a copy of the declarations page and any refund checks for the cost reporting period.
- The Department may request additional information during the review of the Worker's Compensation plan.

If the plan is self-insured but not through a captive or qualifying trust, the nursing facility is required to:

- Provide the specific and aggregate attachment point for stop loss.
- Submit a report of claims paid from the insurance carrier.
- Submit a copy of the plan documents including those documents outlining the nursing facility's administrative fees and stop loss fees.
- If the stop loss premiums and the administrative fees are shared with other providers, provide the total costs and allocation to each facility as well as the allocation basis.
- Provide a summary of the monthly stop loss premium the administrative fees for the cost reporting period.
- Provide a copy of the audited financial statements.
- The Department may request additional information during the review of the self-funded plan.

If the self-insured plan is through a captive or qualifying trust as defined by Medicare, the nursing facility is required to:

- Provide a description of the insurer for the self-funded worker's compensation plan.
- Provide the amount of worker's premiums paid to the captive or qualifying trust for the nursing facility.
- Provide the amount of rebates, refunds, dividends, or any other funds received from the captive/qualifying trust or declared by the captive/qualifying trust during the cost reporting period.
- Provide the captive or trust fund financial report for the cost report period.
- Provide the independent actuarial determination of the fund contribution for any period included in the cost report.
- Provide the premium notices from the insurer for the period and any related audits including any allocation worksheets.
- Nursing facilities are expected to submit comparable insurance bids from non-related parties upon request.

- The Department may request additional information during the review of the captive or qualifying trust self-funded plan.

DHS requires the following documentation submission for Line 9024: Facilities with costs on line 9024 of this Cost Report form in the "Nursing Facility Related Costs" column are required to complete a detailed schedule of these costs. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

9025

Report the employer portion of the dental insurance expense for the reporting period. The employee deductions withheld for dental insurance should offset the employer portion of the dental insurance.

Allowable costs for self-funded insurance plans include both the actual claims paid and administrative costs. Both categories are recognized as dental insurance costs on the Cost Report. The employee deductions withheld for dental insurance should offset the cost of the self-insured plan.

9026

Report the employer portion of the pension expense for the reporting period. Pension expense includes Profit Sharing, 401(K), and 403(b). The allowable contributions are limited to the employer's actual contributions of obligated amounts related to the period.

Pension expense should be reduced by any forfeiture amounts related to the reporting period. The nursing facility must provide a copy of the plan documents and a detailed spreadsheet that shows funding by employee for both the employee and employer portion. Estimates in pension expense are not allowable on the cost report.

DHS requires the following documentation submission for Line 9026: Facilities with costs on line 9026 of this Cost Report form in the "Nursing Facility Related Costs" column are required to complete a detailed schedule of these costs. Please see the Supplemental Schedule on the NF Provider Portal for additional information and a sample schedule. To expedite the DHS audit, the Department prefers to receive the Supplemental Schedule information in an Excel format.

9080

"Other Employee Benefits" includes, employee physicals, costs for employee vaccinations and flu shots, employee x-rays required for positive mantoux test, employee uniforms, childcare costs, and in-kind benefits. Expenses reported here must not be reported on lines 9210 to 9280. Drug/alcohol testing, employee meals for work-related meetings, and employee background checks should be reported on Line 8080.

COVID-19 testing costs for staff may be allowable on the cost report if the costs cannot be reimbursed from other payor sources. Allowable costs for COVID-19 testing are limited to the Medicare Fee Schedule in effect on the date of service. Reimbursement from DHS will be the lessor of the actual lab charges or the Medicare fee schedule payment amount. If the lab is a related party to the nursing facility the CMS reimbursement rules pertaining to related parties will apply. If the nursing facility is using in-house nursing staff to collect specimens,

a separate fee for that service will not be allowed on the cost report. Nursing facilities must maintain records of the COVID-19 testing costs they have incurred and make this information available to the Department upon request. These records must be kept for seven years. If the nursing facility is seeking reimbursement from DHS for COVID-19 test costs, this documentation must include the employee's name and test date(s) for all tests the facility has paid for the employee. These records shall include documentation that the facility has incurred these costs, the costs were allowable, and that the facility has paid for these costs in full.

9095

Hospital-attached facilities that report costs using Line 9095 should not include costs as defined for Line 9080 on this cost report line. The costs related to Other Employee Benefits should be reported on Line 9080.

9110 - 9200

These lines are optional and should be completed only if you choose to directly identify payroll taxes and fringe benefits to each cost category. However, if the fringe benefits and payroll taxes reported on lines 9011 through 9026 cannot all be directly identified -- leave lines 9110-9200 blank -- and the costs will be allocated based on a ratio of salary costs.

External Fixed

7012

Only amounts paid for real estate taxes related to the nursing facility should be reported on this line. Real estate taxes should be calculated using the county property tax statements. A sample calculation is shown below and utilizes the two property tax statements that were paid during the reporting year. The second half is calculated using 25% of the costs and the first half is calculated using 75% of the costs to correspond with the months reported on the cost report. Use the adjustment column to reduce the tax for all non-nursing facility square footage. Special assessments paid during the reporting year should be reported on line 7014.

SAMPLE CALCULATION FOR REAL ESTATE TAXES

Property Tax Statement 2nd half, 2024	$10,000	$ 2,500
Property Tax Statement 1st half, 2025	$12,500	$ 9,375
Total real estate taxes paid (before square footage adj)		$11,875

Nonprofit organizations making payments in lieu of real estate taxes must document the amount claimed on line 7012. This documentation must be available if requested by the Department. The amounts for fire, police, sanitation, and road maintenance services may be claimed. Use the adjustment column to reduce the tax for all non-nursing facility square footage.

CALCULATION OF MAXIMUM PAYMENT IN LIEU OF REAL ESTATE TAXES

Minnesota Statutes, section 256R.25 (i) provides,

"… Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes must not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes."

Facilities claiming amounts for payments in lieu of real estate taxes should be prepared to provide the following upon request by the Department:

- Tax capacity of the facility (show how the amount is computed);
- Tax capacity rates for fire protection, police, sanitation, and road maintenance;
- Any other information needed to compute the amount paid in lieu of real estate taxes; and
- A signed statement from the County Assessor, City or Township Clerk, and County Auditor verifying the amounts used for the tax capacity and the tax capacity rates for the four services are correct.

SAMPLE CALCULATION OF PAYMENT IN LIEU OF TAXES

TAX CAPACITY		25,795
Market Value of Facility	737,000	
Times Tax Capacity %	x 3.5%	
Tax Capacity	25,795	
TAX CAPACITY RATES		
Fire Protection	2.6407	
Police	4.8768	
Sanitation	15.9093	
Road Maintenance	19.4668	
Total Capacity Rate		42.8936
MAXIMUM PAYMENT IN LIEU OF REAL ESTATE TAXES		11,064

NOTE: This is the maximum that would be allowable. If this is not the actual amount being paid to the county, you will also include the actual amount that will be paid with the information submitted upon request.

7014

Special assessments paid during the reporting year should be reported on this line. Please refer to the methodology for calculating the special assessment paid utilizing the formula in the sample calculation of real estate taxes. Use the adjustment column to reduce the special assessments for all non-nursing home square footage. Special assessments should not include costs that are voluntary or special assessments for projects that are reimbursed in the property rate. Special assessments must not be included with real estate taxes on line 7012.

7015

Only the Minnesota Department of Health nursing facility license fee costs are to be reported on this line.

7017

Only the allowable expenses related to the scholarship program should be reported on this line.

These expenses are limited to amounts related to tuition, mandatory fees, required books and supplies, allowable childcare costs, and transportation expenses related to direct educational expenses, nursing assistant training, testing and associated expenses, reimbursement for qualified student loan expenses and Adult Basic

Education (ABE) Training costs. Contact the Department Scholarship Program staff for instructions on how to report in-house training for nursing assistants.

The amount reflected in the "Nursing Facility Related Costs" column must tie to the total facility scholarship expenses calculated by the system in Scholarship section of the Cost Report form on the NF Provider Portal. Only whole dollars are accepted in this field. The total (system calculated) facility scholarship amount in section seven should be rounded to the next whole dollar and entered here. **For additional instructions to report scholarship costs, refer to the section titled "NF Employee Scholarship Program" at the end of this instruction manual.**

7018

Report the cost of PERA contributions on this line. Provider contributions payments made to a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider (see PRM Section 2142.6). Estimates of PERA contributions are not allowable on the Cost Report.

7020

Report the cost of Resident & Family Advisory Council Fees on this line.

9021

Report the employer contributions to Health Savings Account and Health Reimbursement Arrangements.

Report the cost of Individual Coverage Health Reimbursement Accounts (ICHRA) on Line 9021. Certain conditions must be met including, but not limited to:

- The coverage needs to be limited to health insurance premiums and copays for MN nursing facility employees, no dental or other payments, and
- The Department needs to see, upon request, documentation of the plan coverage and the costs paid out, and
- The provider must be able to separate and clearly identify any payments for dependents of part time employees.
- If a provider purchases services or products from a related organization, those costs can only be reimbursed to the provider at the cost of the related organization.

9022

Report the employer portion of the group medical insurance expense for the reporting period.

Do NOT include dental insurance, life insurance, or vision insurance expense on this line; employee dental insurance expense is to be reported on line 9025 and life and vision insurance is to be reported on line 9023.

Per MN Statutes, Section 256R.02, Subd. 18: "Employer health insurance costs" means

- premium expenses for group coverage;
- actual expenses incurred for self-insured plans, including actual claims paid, stop-loss premiums and plan fees. Actual expenses incurred for self-insured plans does not include allowances for future funding unless the plan meets the Medicare requirements for reporting on a premium basis when the Medicare regulations define the actual costs; and employer contributions to employer-sponsored individual coverage health reimbursement arrangements as provided by Code of Federal Regulations,

title 45, section 146.123, employee health reimbursement accounts, and health savings accounts. Employer health insurance costs are allowable for (1) all employees and (2) the spouse and dependent of those employees who are employed on an average at least 30 hours per week.

- The commissioner must not treat employer contributions to employer-sponsored individual coverage health reimbursement arrangements as allowable costs if the facility does not provide the commissioner copies of the employer-sponsored individual coverage health reimbursement arrangement plan documents and documentation of any health insurance premiums and associated co-payments reimbursed under the arrangement. Documentation of reimbursements must denote any reimbursements for health insurance premiums or associated co-payments incurred by the spouses or dependents of employees who work on average less than 30 hours per week.
- Employee deductions withheld for group medical insurance should offset the employer portion of the group medical insurance.

Allowable costs for self-funded insurance plans, not funded through a recognized trust, include both the actual claims paid and administrative costs. Both categories are recognized as health insurance costs on the Cost Report. Reasonable broker fees related to health insurance are allowable as part of the administrative cost portion. Broker fees must be usual and customary to be allowable as a reimbursed expense and the total costs of the self-funded plan must be less than the cost of comparable third-party insurance coverage in all cases. In the case of a self-funded insurance plan meeting the requirements to be reimbursed on a premium basis, the broker fees and other administrative fees must be paid from the premiums and not included elsewhere on the Cost Report.

The requirements of the Centers for Medicare and Medicaid Services, Provider Reimbursement Manual, Part 1 (PRM), section 2162.5, which specifically limits allowable first dollar losses not funded through a trust and not covered by an aggregate stop-loss policy for self-insurance. This test is defined as "a reasonableness test as to whether the provider is acting prudently."

MN Statute 256R.02 Subd. 5 defines allowable costs as being in accordance with the interpretations in the PRM and 256R.10 indicates that to be an allowable cost the cost must be no more than what a prudent and cost-conscious businessperson would pay. Section 2162.5 of the PRM refers to the amount of losses that can be covered without funding through an approved trust; the 10% of net worth or $100,000.

The PRM requires under Section 2162(c) that providers document the costs of their self-insured health insurance plan to comparable fully funded commercial insurance upon conversion to self-insurance and periodically thereafter, usually every three to five years. In certain cases, the Department may require more frequent third-party comparisons. The requirement for captive self-insurance plans is annual third-party comparison.

DHS requires the following documentation submission for Line 9022: If self-funded through a Medicare qualified trust plan or captive the facility must submit the plan report and related documentation to DHS by the Cost Report submission deadline. Your self-funded plan needs to be reviewed and approved by DHS to be considered for reimbursement. If the facility is self-funded for health insurance, other than through a Medicare qualified trust plan or captive, the facility must submit a breakdown of the costs which include claims paid, employee contributions, drug rebates and all other received, and administrative fees by the Cost Report submission deadline.

The Department may request the employer sponsored health plan contract and network agreement. Facilities are expected to provide the requested information to the Department immediately upon request.

When a change is made from commercial insurance to one of the alternatives, or from one alternative to another, the provider must document a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of coverage is consistent with sound management practices. The provider's comparative analysis should be performed on a periodic basis to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider should plan to make this documentation available to DHS as it may be used in determining the reasonableness of the insurance costs. These analyses must comply with the requirements specific in the CMS Provider Reimbursement Manual.

7021 - 7029

Record depreciation expense on these lines. Depreciation expense associated with non-nursing home assets should be removed in the adjustments column (e.g. attached hospitals, outpatient therapy areas, etc.) Refer to "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association for guidance.

7031

Facility capital debt and lease interest expense includes all interest and finance charges. It does not include working capital interest expense.

7051 - 7059

Record the nursing facility's short-term (less than one year in length) lease or rental agreement information. Long-term leases and rentals are reported on line 7070. NOTE: Long-term leases that are 12 months in length or greater, but less than $2,000, are to be reported on line 7053.

7059

Rental of off-site space for record storage or other purposes should be recorded on this line.

7070

Report long-term lease expense on this line. Long-term is defined as 12 months or greater and at least $2,000.

Total Operating Expense

9300

The total balance per books should reconcile to total operating expense per your general ledger. Total operating expenses should equal the total reported for care related, support services, general and administrative, payroll taxes and benefits, external fixed, depreciation, interest and lease and rental expense.

Revenue

9410 - 9440

Report all revenue for resident related care on these lines according to payor source. Revenue reported as an applicable credit in the operating expense sections of the cost report should be removed in the adjustments column in the revenue section of the report. Revenue adjustments would also include (be equal to) amounts recorded in the operating expense sections as an offset (applicable credit) to therapy, pharmacy, or other ancillary services. For example, $500,000 in contract therapy expense was adjusted from allowable expense because therapy is separately reimbursed. You must enter an adjustment of $500,000 in the revenue section of the report to reduce the revenue account for that amount.

All revenue reported in the Balance per Books column must be reported as a negative number. Adjustments made to the Balance per Books in the adjustment column may be entered as a negative number to increase revenue or a positive number to decrease revenue.

Medicare or other third-party revenue should include the contractual adjustments in the balance per books column rather than the adjustments column.

Description of Revenue	Where to record on Cost Report
Private room differential for a Medicaid resident; MA is the payor.	MA, line 9410
Medicaid gross adjustments	MA, line 9410
Payment for Medicaid resident by MA for bed hold day(s)	MA, line 9410
Private room differential for a Medicaid resident; Resident/Guarantor is the payor.	PP, line 9420
Spend-down for Medicaid resident; Resident is the payor.	MA, line 9410
Medicare co-insurance; Resident/Guarantor is the payor.	MC, line 9430
Payment for Medicaid resident by Guarantor or family member for bed hold.	PP, line 9420
Contractual adjustments for Medicare.	MC, line 9430
Medicare co-insurance bad debt for dual eligibles.	MC, line 9430
Hospice	Other, line 9440
Medicare cost report settlements for prior year(s).	Put to prior year; not on Cost Report.

9450

Record other revenue such as vending income, restricted interest income, revenue not directly related to the operation of the nursing facility, and contributions, etc. on this line. The adjustments column should be used to remove revenue not directly related to the operation of the nursing facility. For expenses offset in the operating expense section of the report there should be a corresponding revenue adjustment.

9460

Gain or loss on disposition of assets. The gain or loss will be based on the selling price and either: 1) the original cost or 2) the book value and accumulated depreciation. The sum of book value and accumulated depreciation is the original cost of an asset.

Net Income

Balance Per Books "Total Revenue" (line 9400) less Balance per Books "Total Operating Expense" (line 9300) should equal your "Net Income" on your financial statements.

Section 7: Assets/Debts/Leases

Square Footage

9510

Record the total square footage of the therapy area.

9520

"Other Non-nursing Home Area" includes, but is not limited to, assisted living, day care, coffee shops, etc. In computing the square footage of a non-nursing facility usage area, use inside wall to inside wall area.

9525

Hospital Space refers to the gross square footage of the attached hospital (the footprint).

9530

"Unused Space" includes, but is not limited to, units or wings of the nursing home no longer used for resident care or storage of equipment/records.

9540

Report the gross square footage of the nursing facility less any square footage already accounted for above. Gross square feet includes both direct assigned (e.g. resident, laundry, housekeeping) and undefined (common) areas such as hallways, stairwells, lobby, chapel, and solarium.

Current Assets

1360 - 1369

Capital Assets: For each type of capital asset listed, record the nursing facility's fiscal year-end balances and any additions or disposals to those capital assets since the provider's fiscal year-end to arrive at balances as of the report year-end date identified on page one of this document.

- Disposals should be recorded as a negative number.
- Do not record corporate, affiliated, or central office capital assets since they are not used by the nursing facility in the provision of nursing care services.

To determine whether to report an asset in this section depends on whether the additions were required to be capitalized according to GAAP. Hospital-attached facilities that cannot directly identify changes in the nursing facility's capital assets are to use the Medicare step-down method to allocate the costs.

1370

Accumulated Depreciation is the sum of all depreciation expense claimed for all the facility's active assets. If an asset is fully depreciated, the cost of the asset is the amount to report in Accumulated Depreciation if that asset is still being used for resident care. Assets that have been disposed are not to have any value included in

Accumulated Depreciation. The facility may have more than one Accumulated Depreciation value (e.g. one for Medicare, one for taxes, one for books). Report the book balance on the cost report. In some instances, Medicare allows assets to be depreciated above their cost. If you do not have a book balance and will be reporting the Medicare value, do not include amounts that represent depreciation above an asset's cost.

1371

Funded depreciation is actual money (cash account) set aside for the replacement of capitalized assets.

Debt

General

- All current debts with capital assets pledged as collateral are to be reported.
- Detail of working capital debt is not required.
- Working capital debt interest expense is to be recorded on line 8050, Net Working Capital Interest Expense.
    - Working capital debt is defined as a loan that is not secured by capital assets, but is secured by commitments to current assets, such as receivables, or has no security other than the provider's good name.
- The provider is to report all debt currently held.
- Debts recognized for rate setting purposes in the past but not currently held should not be reported.
- Hospital-attached facilities that do not directly identify the debt associated with the nursing facility's capital assets are to use the Medicare step-down method to allocate the amounts. Report only the nursing facility share of debt associated with a hospital-attached facility.

Construction in Progress (CIP)

The identifying code for the loan type created to handle construction project draws over time is "19," referred to as "Construction in Progress (CIP)." The sum of the draws for the reporting year should be reported as negative principal payments for CIP loans. The reporting year that the project is completed a new loan should be reported on the cost report with a new loan code number/type assigned.

Debt Information

Loans reported on the prior year's cost report are displayed here. For each existing loan click on the "Select" button and update the reported information as needed. If a loan is listed and no longer exists, select the "Delete" button to remove the loan. New debt can be added by selecting the "Create Loan" button.

For all debts, the following are general explanations of the data fields.

- **Date of Loan:** Enter the date the loan agreement was signed.
- **Type of Loan:** Enter the code below which most closely corresponds to the type of loan listed.
- **Type of Capital Asset Associated with the Loan. Select from the following codes/descriptor:**

- 10. Land
- 11. Building and Building Improvements
- 12. Attached Fixtures
- 13. Land Improvements
- 14. Depreciable Equipment (other than vehicle)
- 15. Vehicles
- 16. All the above items
- 17. Codes 11, 12, and 13
- 18. Codes 11, 12, 13, and 14
- 19. Construction in Progress (CIP)

- **Length of Loan (in months):** The length of the loan must be recorded in months (i.e. 25 years should be recorded as 300), report demand notes with a length of zero months. The length of the loan is the original term, not the remaining term of the debt.
- **Amount Originally Borrowed:** Enter the original principal borrowed.
- **Effective Interest Rate (%):** The effective interest rate including the effective points, financing charges, and amortization of bond premium or discount must be recorded for each loan. For those loans which have variable or adjustable rates, the effective interest rate is determined by dividing the interest expense including points, financing charges, and amortization of bond premium or discount for the reporting year by the average allowable debt. Interest rates are to be entered as whole numbers as opposed to decimals. For example, 4% is entered as 4 not .04.
- **Interest Expense this Reporting Year:** Interest expense includes actual interest payments made during the reporting year plus the amortization of any financing charges and/or amortization of bond premium or discount.
- **Interest Income from Bond Reserve Funds:** Record interest income from bond reserve funds.
- **Principal Balance Beginning This Year:** Loans taken out during the reporting year should show a beginning balance of zero.
- **Principal Payments (this year):** Principal payments are the portion of debt service that is not interest or the balance of a loan paid to refinance the debt. For CIP loans report negative principal payment(s) to reflect project draws.
- **Principal Balance Refinanced (this year):** If debt was consolidated or refinanced during the reporting year, enter the principal balance on the date the debt was refinanced.
- **Debt Service Payments:** Record the periodic payment amount required to be sent to the debt holder according to the agreement between the borrower and lender. It is not the amount actually paid during the year.
- **Frequency of Debt Service Payments:** Record how often the Debt Service Payments are to be made according to the agreement between the borrower and lender. If payments are due monthly, enter 12; if quarterly, enter 4; if semi-annually, enter 2; if annually, enter 1.

- **Variable Interest Rate Loan:** If the loan has a variable interest rate loan, check "Yes".
- **Restrictions on Refinancing the Loan:** If there are restrictions on refinancing the loan, check "Yes".

Leases

These lines are to be used to record the nursing facility's long-term lease or rental agreement information. Corporate, affiliated, or central office lease costs for capital assets not used directly by the nursing facility should not be recorded here. Short-term leases and rentals (less than one year in length) are reported on line 7051-7059.

For all leases, the following are general explanations of the data fields.

- **Type of Lease:** Use the code which best describes the nursing facility's lease or rental agreements.
- **Type of Capital Asset Leased. Select from the following codes/descriptor:**
  - 10. Land
  - 11. Building and Building Improvements
  - 12. Attached Fixtures
  - 13. Land Improvements
  - 14. Depreciable Equipment (other than vehicle)
  - 15. Vehicles
  - 16. All the above items
  - 17. Codes 11, 12, and 13
  - 18. Codes 11, 12, 13, and 14
- **Lease Amount:** Enter the total cost of the lease or rental agreement over the entire term of the lease.
- **Lease Expense this Reporting Year:** Enter the actual payments made under the lease agreement during the reporting year.
- **Beginning and Ending Lease Balances:** Enter the amounts remaining to be paid under the lease agreement on these dates.
- **Frequency of Lease Payment:** Enter how often the payments are required. If payments are due monthly, enter 12; if quarterly, enter 4; if semi-annually, enter 2: if annually, enter 1.

Section 8: NF Employee Scholarship Program

If you have questions about the scholarship program, please contact Munna Yasiri via email at munna.yasiri@state.mn.us

SCHOLARSHIP CONTACT INFORMATION

In the following three fields, enter contact information for the facility staff person who works with the Employee Scholarship Program. This should be a staff person who is able to answer detailed questions about scholarships your facility has awarded. Do NOT enter the name of the individual that received the scholarship. Once you have saved a scholarship record, the Facility Scholarship Contact Information will automatically "populate" for all subsequent scholarship records you enter.

- **Contact Name:** Enter NF employee scholarship program facility contact name.
- **Contact Phone:** Enter NF employee scholarship program facility contact telephone number in the format (111) 234-5678 or 111-234-5678.
- **Contact Email:** Enter NF employee scholarship program contact facility email address. Do NOT enter the email address of the individual that received the scholarship.

EMPLOYEE DATA

In the following field, enter data on the NF employee that received the scholarship award.

- **Employee Number:** Enter complete employee number.

EDUCATIONAL DATA

The following fields should be completed with information on the nature of the training the employee was granted a scholarship for.

- **Program or course:** Select an option from the drop-down menu for the educational/training program the employee is taking.
- **If "28-Other Program" please list:** If you selected "Other Program" (option 28) in the previous field, this box will appear and you must provide an explanation or description of the type of education/training here.
- **Level:** Select the level of the educational program the employee is taking or select "other."
- **If options 7-8 selected, please explain:** If you selected options 7-8 in the "Level" field above, you must enter an explanation of the level of education/training the employee is taking here (e.g. individual course).

ELIGIBLE SCHOLARSHIP EXPENDITURES

In the following eight fields, enter the amount of eligible facility scholarship expenditures related to this individual scholarship only. Enter dollars and cents with the decimal point. Do NOT enter commas or dollar sign ($).

- **Tuition and Mandatory Fees:** Enter facility expenditure for tuition and mandatory fees (e.g. 1500.00).
- **CNA Training and Testing Costs:** Enter facility expenditure for training and testing expenses for nursing assistants. This field should include only the costs of the training course and testing (competency evaluation) fee. Other costs such as books, mileage, other required fees and supplies, must be reported in that specific category (e.g. books, fees, supplies, etc.).

- **Required Books:** Enter facility expenditure for required books (e.g. 30.40).
- **Required Supplies:** Enter facility expenditure for required supplies (e.g. 30.50).
- **Transportation:** Enter costs for transportation expenses that are related to direct educational expenses.
- **Childcare:** Enter costs for childcare expenses that are related to direct educational expenses.
- **Student Loan Reimbursement:** Enter the nursing facility cost to reimburse student loan expenses for eligible registered nurses and licensed practical nurses.
- **Adult Basic Education (ABE) Training Costs:** Enter the nursing facility cost to reimburse qualifying entities for ABE training provided a nursing assistant.
- **Total:** No entries are allowed in this field. The system will automatically total all previously entered expenditures for this scholarship record and display the total in this field.

Save/Cancel Scholarship Entry

After each record, click on "check for errors and save record" to save each individual scholarship entry or click on "cancel record" if you do not wish to save this individual scholarship record.

Printing Instructions

On the left-hand side of the screen under the "tasks" section, click on the "Print the Cost Report" link. This will open a "pdf" version of the entire cost report. You have the option to print the entire report or enter the page numbers for the scholarship section alone.

Exhibit 1

2025 Cost Classification Table of Potential Allowable Costs – Fees, Purchased Services, and Software

NOTE: This table is not a comprehensive list of all possible allowable costs; the expenses listed in this table are only common items that may be allowable, and the table identifies which Cost Report Form Section and Line Number to report the expenses on the Cost Report.

Expense	Line Number	Cost Report Form Section
Accounting Fees	8080	G&A
Activities – art programs, music therapy	6220	Supplies & Non-Prescription Drugs/Pharmacy
Activities Driver, employee	6212	Care Related Salaries
Activities Driver, non-employee	6220	Supplies & Non-Prescription Drugs/Pharmacy
Advertising – Yellow pages, employment	8080	G&A
Allscripts	8080	G&A
Aromatherapy – purchased services	6220	Supplies & Non-Prescription Drugs/Pharmacy
Aviaries – bird seed, aviary maintenance provided by the contracted aviary company	6220	Supplies & Non-Prescription Drugs/Pharmacy
Background checks – employee	8080	G&A
Bad Debt – Collection Expense	8080	G&A
Board of Director Fees	8080	G&A
Consultants – social services, activities, religious, medical records	6179	Consultants
Consultants – interim nursing administration (third-party)	6150	Consultants
Consultants – interim nursing administration (corporate office)	6176	Consultants
Consultants – utilization review, pharmacy, in-service, medical director, licensed nursing, infection control, psychologist, psychology, psychiatry	6176	Consultants
Consultants - billing, revenue	8080	G&A
Dental Service – consulting contract, Dental Director	6176	Consultants
Dental Service – transportation, travel, and setup fees	8080	G&A
Dietary – external consultants	6380	Dietary Services
Dietary – outside management contract	6380	Dietary Services

Expense	Line Number	Cost Report Form Section
Entertainers, Activities	6220	Supplies & Non-Prescription Drugs/Pharmacy
Fees – professional organizations, licenses, permits not relating to external fixed	8080	G&A
Fingerprinting – employee	8080	G&A
Fit Testing, Respirator (contracted)	6176	Consultants
Garden – flowers and plants planted by residents	6220	Supplies & Non-Prescription Drugs/Pharmacy
Housekeeping – outside management contract	6580	Housekeeping Services
Integra Scripts	8080	G&A
Interpreter Services – employed by facility	6211	Care Related Salaries
Interpreter Services – non-employee	6179	Consultants
IV – start for hydration, CPT-4 96360	6176	Consultants
Lab Transportation Costs	8080	G&A
Landscaping – plants, tools, lawn, and garden care products	6680	Plant Operations & Maintenance Services
Laundry – outside management contract	6480	Laundry Services
License Fee – Administrator	8080	G&A
License Fee – Centers for Medicare & Medicaid (CMS) Application or Renewal	8080	G&A
License Fee – MN Dept. of Health (MDH)	7015	External Fixed Costs
Lodging, all staff	8080	G&A
Meals, all staff	8080	G&A
Pet Care	6220	Supplies & Non-Prescription Drugs/Pharmacy
Piano Services	6220	Supplies & Non-Prescription Drugs/Pharmacy
Recruitment – Foreign Nurse	8080	G&A
Rental – bed rental, copier rental or copier lease, equipment rental	7053	Lease & Rental
Resident Bill of Rights – posters, forms	6220	Supplies & Non-Prescription Drugs/Pharmacy
Salaries – Administrator, Assistant Administrator	8013	G&A
Salaries – Admissions Staff, Social Workers	6211	Care Related Salaries
Scholarship Costs – student loan reimbursement for Registered Nurses and Licensed Practical Nurses	7017	External Fixed Costs
Scholarship costs – CNA training, CNA tests, nurse aide training, certified nurse aide training, nursing assistants	7017	External Fixed Costs
SNSA – administrative fees	8080	G&A
SNSA – shift fees, Actual travel and lodging	8080	G&A

Expense	Line Number	Cost Report Form Section
Software – Ability, Rycan, Align, Data Interface, Resident Trust modules, Referral modules, Third Party Interface, Hosting, Support, Eligibility Verification	8080	G&A
Software – American Data	6180 – 46.8% 8080 – 42.6% Not Allowed – 10.6%	Other Care Related G&A Not Allowable
Software – Billing, Resident Trust	8080	G&A
Software – Clinical	6180	Other Care Related
Software, Clinical – Providigm	6180	Other Care Related
Software, Curaspan	8080	G&A
Software, Direct Supply TELS Basic Access Fee	6680	Plant Operations & Maintenance Services
Software, EarlySense	7053	Lease & Rental
Software – Encounter Alert Service (EAS) Powered by Audacious Inquiry	6180	Other Care Related
Software – PointClickCare EMR Advantage Pkg.	6180 – 75% 8080 – 25%	Other Care Related G&A
Software-PointClickCare Skilled Nursing Value Pkg.	6180 - 67% 8080 – 33%	Other Care Related G&A
Software – Sandbox Training/Database	8080	G&A
Software – Documentation Storage	8080	G&A
Software – Eligibility Verification	8080	G&A
Software – General Ledger, Accounts Payable	8080	G&A
Software – Point of Care	6180	Other Care Related
Software – Mobile MDS	6180	Other Care Related
Software – Third Party Interfaces	8080	G&A
Software – Integrated Medication Management	6180	Other Care Related
Software – ODS – Weekly Extract	8080	G&A
Software – Practitioner Engagement	6180	Other Care Related
Software – Resident/Community Event Calendar	8080	G&A
Software – Integrated Results Tracking	8080	G&A
Software – Skin and Wound	6180	Other Care Related
Software – Point Click Care Plus/SmarthPath	8080	G&A
Software – Lab Integration	8080	G&A
Software – Laboratory and Radiology Int. Results	8080	G&A
Software – Optum ICD-10 Software	8080	G&A
Software – Net Health Systems, non-therapy modules	6180 – 40% 8080 – 60%	Other Care Related G&A
Software – eClaims Monthly Fee	8080	G&A

Expense	Line Number	Cost Report Form Section
Software - Employee Engagement	8080	G&A
Software - Secure Conversations/Messaging	8080	G&A
Software – Infection Control	6180	Other Care Related
Software – Nursing Advantage (formerly Care Control)	6180	Other Care Related
Software – Skilled Nursing Elements	6180 – 50% 8080 – 45.8% Not allowed – 4.2%	Other Care Related G&A Not Allowable
Software – Basic VIS Integration	8080	G&A
Software – Infection Prevention and Control	6180	Other Care Related
Software – Care Insights	6180 – 33.33% 8080 – 66.67%	Other Care Related G&A
Software – RealTime	6180 – 57.1% 8080 – 42.9%	Other Care Related G&A
Software – SL Prime Plus	6180 – 45.45% 8080 – 50.05% Not Allowed – 4.5%	Other Care Related G&A Not Allowable
Software – Cliniconex	6180	Other Care Related
Software – Rosie Connectivity	6180	Other Care Related
Subscriptions	8080	G&A
Surcharge – DHS, Nursing Facility (penalties for late payment of this is not allowable)	7011	External Fixed Costs
Testing – Drug/Alcohol (employee)	8080	G&A
Television Services – cable and other streaming services in common areas only	6220	Supplies & Non-Prescription Drugs/Pharmacy
Training – direct care personnel (RN, LPN, CNA, TMA, and Nursing Admin)	6261	Supplies & Non-Prescription Drugs/Pharmacy
Training – non-direct care personnel	8080	G&A
Trash – garbage disposal, waste disposal, trash removal, hazardous waste disposal, infectious waste, pharmaceutical waste, medical waste	6680	Plant Operations & Maintenance Services
Travel, Employee – lodging, meals, mileage	8080	G&A
Travel, SNSA – actual cost of travel and lodging	8080	G&A
X-Rays, Nursing Facility Employee Related to Mantoux	9080	Payroll Taxes and Fringe Benefits

Exhibit 2

2025 Cost Classification Table of Potential Allowable Costs – Minor Equipment and Supplies

NOTE: This table is not a comprehensive list of all possible allowable costs; the expenses listed in this table are only common items that may be allowable, and the table identifies which Cost Report Form Section and Line Number to report the expenses on the Cost Report.

Expense	Line Number	Cost Report Form Section
A&D Ointment	6120	Supplies & Non-Prescription Drugs/Pharmacy
Abdominal Pads	6120	Supplies & Non-Prescription Drugs/Pharmacy
Additive, bath	6580	Housekeeping Services
Adhesive, denture	6120	Supplies & Non-Prescription Drugs/Pharmacy
Air Fresheners	6580	Housekeeping Services
Alarms – bed, patient, Wanderguard bracelets, anklets	6680	Plant Operations & Maintenance Services
Alcohol – wipes, prep pads, rubbing alcohol	6120	Supplies & Non-Prescription Drugs/Pharmacy
Apron, Smokers	6680	Plant Operations & Maintenance Services
Aromatherapy – supplies	6220	Supplies & Non-Prescription Drugs/Pharmacy
Bag – patient handling, resuscitator	6120	Supplies & Non-Prescription Drugs/Pharmacy
Bag – Ziploc, brown paper	6380	Dietary Services
Bag – trash, can liners, plastic waste	6680	Plant Operations & Maintenance Services
Basin – emesis, wash, bed pan disposable	6120	Supplies & Non-Prescription Drugs/Pharmacy
Basin – wash, bedpan reusable, auto-clavable	6680	Plant Operations & Maintenance Services
Batteries – all	6680	Plant Operations & Maintenance Services
Belt, Gait	6680	Plant Operations & Maintenance Services
Bib, clothing protector	6480	Laundry & Linen
Bib, Smoker	6680	Plant Operations & Maintenance Services
Blanket, weighted	6480	Laundry & Linen
Bleach, wipes and bottles	6580	Housekeeping Services
Blood Collection Sets	6120	Supplies & Non-Prescription Drugs/Pharmacy
Blood Pressure – cuffs, units	6680	Plant Operations & Maintenance Services
Board, emery	6120	Supplies & Non-Prescription Drugs/Pharmacy
Board, CPR	6680	Plant Operations & Maintenance Services
Boot, heel	6120	Supplies & Non-Prescription Drugs/Pharmacy
Brush – denture, nail, hair	6120	Supplies & Non-Prescription Drugs/Pharmacy
Clipper – fingernail, toenail	6120	Supplies & Non-Prescription Drugs/Pharmacy
Clothing Guard – full length	6680	Plant Operations & Maintenance Services
Commodes – urinals, shower seats, bed pan, bath chair, toileting chair	6680	Plant Operations & Maintenance Services
Computer Equipment – desktop, laptop, printer	6680	Plant Operations & Maintenance Services
Containers – sharps, waste baskets	6680	Plant Operations & Maintenance Services

Expense	Line Number	Cost Report Form Section
Cover – probe, shoe	6120	Supplies & Non-Prescription Drugs/Pharmacy
Cushions – wheelchair, gel, seat, saddle, dry flotation, wedge	6680	Plant Operations & Maintenance Services
Cups, medication/soufflé 1 oz.	6120	Supplies & Non-Prescription Drugs/Pharmacy
Cups, drinking disposable	6380	Dietary Services
Diabetic – supplies, test strips, lancet, solution	6120	Supplies & Non-Prescription Drugs/Pharmacy
Diffuser, aromatherapy	6220	Activities
Dressings, medical use only	6120	Supplies & Non-Prescription Drugs/Pharmacy
Forks, plastic	6380	Dietary Services
Forms – physician orders, medication sheets	6120	Supplies & Non-Prescription Drugs/Pharmacy
Forms – attendance, dietary, basic care plans, personal resident inventory sheets, resident activity calendars, vacation request	8080	G&A
Gauze, medical use only	6120	Supplies & Non-Prescription Drugs/Pharmacy
Goggles – PPE	6120	Supplies & Non-Prescription Drugs/Pharmacy
Hair Hygiene Supplies – comb, brush, shampoo provided by beauty shop employees	6220	Supplies & Non-Prescription Drugs/Pharmacy
Hair Hygiene Supplies – purchased in bulk for use in tub rooms or resident rooms for routine daily care	6120	Supplies & Non-Prescription Drugs/Pharmacy
Haircuts – provided by staff	6220	Supplies & Non-Prescription Drugs/Pharmacy
Handbooks – narcotic log	6120	Supplies & Non-Prescription Drugs/Pharmacy
Handbooks – narcotic, drug	6261	Training
Housekeeping – paper towels, toilet tissue, toilet paper, tri-fold towels, Kleenex, facial tissue, disposable dust cloths	6580	Housekeeping Services
Incontinent – briefs, pull-ups, disposable wipes, underpads, chux pads, disposable underwear	6120	Supplies & Non-Prescription Drugs/Pharmacy
Kiosk and Scanner, McKesson	7053	Lease & Rental
Knife, plastic	6380	Dietary Services
Laundry – chemicals, laundry soap	6480	Laundry Services
Lifts – accessories (batteries, slings)	6680	Plant Operations & Maintenance Services
Lifts – patient standing, mechanical (non-capital)	6680	Plant Operations & Maintenance Services
Liners – trash, can	6680	Plant Operations & Maintenance Services
Linens – bed sheets, pillowcases, linen towels, linen washcloths, mattress pads	6480	Laundry & Linen Services
Lotion – hand, body	6120	Supplies & Non-Prescription Drugs/Pharmacy
Mantoux, Tubersol or Aplisol	Residents-6120 Staff-9080	Supplies & Non-Prescription Drugs/Pharmacy G&A
Masks – facemasks medical use	6120	Supplies & Non-Prescription Drugs/Pharmacy
Mattresses – beds	6680	Plant Operations & Maintenance Services

Expense	Line Number	Cost Report Form Section
Monitor – blood pressure, fall guard, wrist	6680	Plant Operations & Maintenance Services
Needles – insulin, safety, hypodermic, syringes	6120	Supplies & Non-Prescription Drugs/Pharmacy
Office Supplies – pen, paper, pencils, staplers	8080	G&A
Otoscope, reusable	6680	Plant Operations & Maintenance Services
Oximeter, pulse	6680	Plant Operations & Maintenance Services
Patient Identification – pre-printed labels, wrist bands	6120	Supplies & Non-Prescription Drugs/Pharmacy
Pet Care	6220	Supplies & Non-Prescription Drugs/Pharmacy
Postage	8080	G&A
Prescription Destroyer, solution	6120	Supplies & Non-Prescription Drugs/ Pharmacy
Radios – walkie-talkie, 2-way, portable	6680	Plant Operations & Maintenance Services
Resident Bill of Rights – posters, forms	6220	Supplies & Non-Prescription Drugs/Pharmacy
Sanitizer, hand (alcohol-based and non-alcohol based)	6120	Supplies & Non-Prescription Drugs/Pharmacy
Slings – arm, ceiling, and mechanical	6680	Plant Operations & Maintenance Services
Slippers, non-slip single patient use	6120	Supplies & Non-Prescription Drugs/Pharmacy
Soap, dishwasher detergent	6380	Dietary Services
Soap, hand	6120	Supplies & Non-Prescription Drugs/Pharmacy
Soap, laundry detergent	6480	Laundry Services
Sponge, cleaning	6580	Housekeeping Supplies
Solution, mask fit testing	6120	Supplies & Non-Prescription Drugs/Pharmacy
Sponge, gauze sterile	6120	Supplies & Non-Prescription Drugs/Pharmacy
Stethoscope, disposable	6120	Supplies & Non-Prescription Drugs/Pharmacy
Stethoscope, reusable	6680	Plant Operations & Maintenance Services
Straws, disposable	6380	Dietary Services
Supplements – dietary used for tube or oral feedings	6330	Dietary Services
Syringes, Insulin	6120	Supplies & Non-Prescription Drugs/Pharmacy
Syringes, Tuberculin	6120	`Supplies & Non-Prescription Drugs/Pharmacy
Teaspoons, disposable	6380	Dietary Services
Thermometer, disposable	6120	Supplies & Non-Prescription Drugs/Pharmacy
Thermometer, reusable life of >1 year	6680	Plant Operations & Maintenance Services
Uniforms – staff	9080	Payroll Taxes & Fringe Benefits
Water - bottled, bulk	6680	Plant Operations & Maintenance Services
Wheelchair and wheelchair accessories – anti-tippers, leg extenders, cushions	6680	Plant Operations & Maintenance Services
Wipes, incontinent and skin cleansing	6120	Supplies & Non-Prescription Drugs/Pharmacy
Wipes, surface and disinfecting	6580	Housekeeping Services

Exhibit 3

2025 Cost Classification Table of Potential Non-Allowable Costs

NOTE: This table is not a comprehensive list of all possible non-allowable costs; the expenses listed in this table are only common items that the Department has determined to be either non-allowable or separately billable in most circumstances.

Expense	Line Number
Advertising – promotional, general facility for prospective residents	Not allowable
Alcohol, consumable (e.g. wine, beer)	Not allowable
Alcohol, resident, happy hour	Not Allowable
Beard Trims – provided by beautician/barber	Separately billable
Bi-Pap, C-Pap, Oxygen Concentrator	Separately billable
Cigarettes, Nicotine Patches	Not allowable
Charitable Contributions, Donations	Not allowable
Clinic Visits	Separately billable
Clothing, resident replacement, personal	Not allowable
Club Memberships – Rotary, American Legion	Not allowable
Companion, private duty	Separately billable
Corporate Income Taxes	Not allowable
Cubex, billed by pharmacy	Not allowable
Dental Service – individual	Separately billable
Dentures	Separately billable
Drugs – prescription	Separately billable
Drugs – prescription, Emergency Medical Assistance	Separately billable
Drugs – lost/stolen, refilled too soon	Not Allowable
Employee, County Worker MN-LTC Eligibility	Not Allowable
Eyeglasses – glasses, visual aides	Separately billable
Fines and Penalties – including late fee and finance charges	Not allowable
Footwear – orthotics, custom	Separately billable
Hair Coloring – provided by licensed beautician/barber	Separately billable
Hair Relaxers – provided by licensed beautician/barber	Separately billable
Haircuts – provided by licensed beautician/barber	Separately billable
Hearing Aids – prescription and over-the-counter	Separately billable
IV – Emergency Medical Assistance	Separately billable
IV – Supplies, Drugs hydration solution bags	Separately billable
IV Infusion Pump (dependent upon pay source)	Separately billable
Laboratory – draws processed off-site	Separately billable
Lobbying Costs	Not allowable
Lost and damaged resident items (including lost/stolen drugs)	Not allowable
LVAD – Left Ventricular Assist Device and Supplies	Separately billable
Mattresses - overlay	Separately billable

Expense	Line Number
Monoclonal Antibody Treatments	Separately billable
Nursing – private duty	Separately billable
Ointment, Corona	Not Allowable
Ostomy Supplies	Separately billable
Over the counter drugs prescribed for a specific resident for scheduled use (not House stock OTC items)	Separately billable
Oxygen – Emergency Medical Assistance	Separately billable
Oxygen, Liquid	Separately billable
Oxygen, Portable tanks	Separately billable
Oxygen, tank rental, cylinder rental	Separately billable
Perms – provided by beautician/barber	Separately billable
Prescription Drugs	Separately billable
Prescription Drugs, Emergency Medical Assistance	Separately billable
Prosthetics	Separately billable
SNSA Costs – over the maximum MDH allowable amount	Not Allowable
Software, Casamba	Not Allowable
Software, Customer Relationship Management	Not Allowable
Software, Jintronix	Not Allowable
Software, Net Health Systems, therapy module	Not Allowable
Software, PointClickCare Fees billed by pharmacy	Not Allowable
Software, Procentive	Not Allowable
Specialty beds – therapeutic	Separately billable
Stockings – compression, surgical	Separately billable
Telephone – resident rooms	Not allowable
Television – resident rooms, cable tv, streaming services	Separately billable
Transportation – medical	Separately billable
Transportation – personal (e.g. to visit family), not medical or activities program related	Not allowable
Vaccine Administration, COVID-19, Residents	Separately billable
Vaccine, COVID-19, Residents	Not Allowable
Vaccine, Flu, Residents	Separately billable
Vaccine, Pneumococcal, Residents	Separately billable
Vaccine, Respiratory Syncytial Virus (RSV)	Separately billable
Vaccine, Shingles, Resident	Separately billable
Vacuum Assisted Closure Device – wound vac, wound vac dressings, wound vac supplies, negative wound pressure therapy	Separately billable
Ventilators	Separately billable
Ventilators, Emergency Medical Assistance	Separately billable
X-Rays of residents	Separately billable