CHAPTER 75-04-05
PAYMENT FOR PROVIDER AGENCIES OF SERVICES TO INDIVIDUALS WITH INTELLECTUAL DISABILITIES - DEVELOPMENTAL DISABILITIES

Section

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75-04-05-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

1. "Absence factor" means a cost component of the residential habilitation direct care rate intended to cover costs when a client is not in the residence.

2. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of costs in the period when incurred, regardless of when they are paid.

3. "Administrative costs" means those costs that are necessary to operate the business but are not client related.

4. "Allowable cost" means the program's actual and reasonable cost after appropriate adjustments for nonallowable costs, income, offsets, and limitations.

5. "Assessment score" means the client's score from the standard assessment tool administered by the department or its designee.

6. "Bad debts" means those amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing covered services that are eligible for payment through Medicaid federal financial participation.

7. "Basic services" means all of the services that provider agencies deliver to clients, including nondevelopmental disabilities services.

8. "Board" means all food and dietary supply costs.

9. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used for client care.

10. "Client" means an individual found eligible as determined through the application of chapter 75-04-06 for services coordinated through developmental disabilities program management on whose behalf services are provided or purchased.

11. "Client-authorized representative" means a person who has legal authority, either designated or granted, to make decisions on behalf of the client.

12. "Client representative" means a client-authorized representative or relative who has maintained significant contacts with the client.

13. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. Community contribution does not include a donation to a charity.

14. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a provider agency are divided for purposes of cost assignment and allocations.

15. "Day habilitation" means a day program of scheduled activities, formalized training, and staff supports to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities must focus on improving a client's sensory motor, cognitive, communication, and social interaction skills.

16. "Department" means the North Dakota department of human services.

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

18. "Depreciable asset" means a capital asset or other asset for which the cost must be capitalized for statement of costs purposes.

19. "Depreciation guidelines" means the American hospital association's guidelines as published by American hospital publishing, inc., in the most recently published "Estimated Useful Lives of Depreciable Hospital Assets".

20. "Direct care staff" means employees who are actively providing support to clients receiving a service from a provider agency.

21. "Direct care wage" means the wage level that is used as the basis of the payment system.

22. "Direct program support costs" means costs that are specific to the service provision of a client, including medical and program supplies.

23. "Documentation" means the furnishing of written or electronic records, including original invoices, contracts, timecards, and workpapers prepared to complete reports or for filing with the department.

24. "Employment-related expenses" means employee benefits, including federal Insurance Contributions Act, unemployment insurance, medical insurance, workers' compensation, retirement, disability, long-term care insurance, dental, vision, life, accrued paid time off, and unrecovered medical costs furnished at the provider agency's cost.

25. "Employment support" means ongoing supports to assist clients in obtaining and maintaining paid employment in an integrated setting. Services are designed for clients who need intensive ongoing support to perform in a work setting. Service includes on-the-job or off-the-job employment-related support for clients needing intervention to assist them in maintaining employment, including job development. Employment support includes individual employment support and small group employment support.

26. "Facility-based" means a facility for individuals with developmental disabilities licensed by the department to provide day services. This definition is not to be construed to include areas of the building determined by the department to exist primarily for nontraining.

27. "Fair market value" means value at which an asset could be sold in the open market in an arm's-length transaction between unrelated parties.

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

29. "Generally accepted accounting principles" means the accounting principles approved by the American institute of certified public accountants.

30. "Group home" means any community residential service facility, licensed by the department pursuant to North Dakota Century Code chapter 25-16, housing more than three individuals with developmental disabilities. "Group home" does not include a community complex with self-contained rental units.

31. "Historical cost" means those costs incurred and recorded on the facility's accounting records as a result of an arm's-length transaction between unrelated parties.

32. "Hospital leave day" means any day that a client is not in the facility, but is in an acute care setting as an inpatient and is expected to return to the facility. A hospital leave day is only available to clients residing in an intermediate care facility for the intellectually disabled.

33. "In-house day" means a day that a client was actually receiving services in the intermediate care facility or residential habilitation setting and was not on therapeutic leave, in the hospital, or absent.

34. "Independent habilitation" means formalized training and staff supports provided to clients on a less than daily basis. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community.

35. "Indirect program support costs" means costs that are neither direct care nor administrative, such as program development, supervision and quality assurance, and are not separately billable.

36. "In-home supports" means supports for a client residing with their primary caregiver and their family to prevent or delay unwanted out-of-home placement. Services may assist the client in activities of daily living, and help with maintaining health and safety.

37. "Interest" means the cost incurred with the use of borrowed funds.

38. "Intermediate care facility for individuals with intellectual disabilities" means a residential health facility operated pursuant to title 42, Code of Federal Regulations, parts 442 and 483, et seq.

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

40. "Life-changing event" means a change in a client's life that will affect his or her support needs for six months or more, including a significant medical event, a crisis situation, a change in living arrangement, aging caregiver, significant medical or behavioral health event in the life of a caregiver, significant change in family functioning, or trauma.

41. "Medical assistance program" means the program that pays the cost of medical care and other services to eligible clients pursuant to North Dakota Century Code chapter 50-24.1.

42. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

43. "Net investment in fixed assets" means the cost, less accumulated depreciation and the balance of notes and mortgages payable.

44. "Other asset" means any asset that has a life of more than one year and has a cost of five thousand dollars or greater.

45. "Parenting supports" means assisting clients who are or will be parents in parenting skills training that is individualized to assist with focusing on the health, welfare, and developmental needs of their child.

46. "Person-centered service plan" means an individual plan that identifies service needs of the eligible client, the services to be provided, and is developed by the client or client-authorized representative, or both, client select team, and developmental disabilities program manager considering all relevant input.

47. "Prevocational services" means formalized training, experiences, and staff supports designed to prepare clients for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the client's person-centered service plan.

48. "Program support" means the direct and indirect program support costs that support providing services to a client.

49. "Program support staff" means employees whose duties are associated with client care but who are not actively providing direct support services to clients receiving a service from a provider agency.

50. "Property costs" means the cost category for allowable costs to operate the owned or leased property.

51. "Provider agency" means the organization or individual who has executed a Medicaid agreement with the department to provide services to individuals with developmental disabilities.

52. "Reasonable cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

53. "Related organization" means an organization which a provider agency is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider agency. Control exists when an individual or an organization has the power, directly or indirectly, significantly to influence or direct the action or policies of an organization or institution.

54. "Relief staff" means the replacement of direct care staff when the regular direct care staff are on leave and there is a cost component in the direct care hourly rate that covers the cost of relief staff.

55. "Residential habilitation" means formalized training and supports provided to clients who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community.

56. "Residential services" means services provided in an intermediate care facility for individuals with intellectual disabilities or residential habilitation.

57. "Room" means the cost associated with the provision of shelter, housekeeping staff or purchased housekeeping services and the maintenance thereof, including depreciation and interest or lease payments of a vehicle used for transportation of clients.

58. "Service" means the provision of living arrangements and programs of daily activities subject to licensure by the department.

59. "Staff training" means an organized program to improve staff performance.

60. "Statement of costs" means the department-approved form for reporting costs, statistical data, and other relevant information of the provider agency.

61. "Statement of costs year" means the fiscal year from July first through June thirtieth.

62. "Therapeutic leave day" means any day that a client is not in the intermediate care facility for individuals with intellectual disabilities, nursing facility, swing-bed facility, transitional care unit, subacute unit, another intermediate care facility for individuals with intellectual disabilities, a basic care facility, or an acute care setting, or if not in an institutional setting, is not receiving home- and community-based waiver services and is expected to return to the facility. A therapeutic leave day is only available to clients residing in an intermediate care facility for the intellectually disabled.

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

64. "Units of service" for billing purposes means:

    a. (1) In residential services, one client served for one 24-hour day;

       (2) In day habilitation, prevocational services, employment supports, and independent habilitation settings, one client served for fifteen minutes; or

       (3) In parenting supports and in-home support settings, one client served for one hour.

    b. The day of admission and the day of death, but not the day of discharge, are treated as a day served for residential services.

65. "Vacancy" means an opening in residential services where a client has not been admitted. A vacancy can occur when a client leaves a residence with no intent to return, or in a residence that has capacity for more clients than those who are currently living in the residence.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; May 1, 2006; July 1, 2010; January 1, 2013; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-02. Eligibility for payment.

Provider agencies of service are eligible for payment for the costs of rendered services contingent upon the following:

1. The provider agency, other than a state-owned or state-operated provider agency, is required to hold a current valid license, issued pursuant to the provisions of chapter 75-04-01 authorizing the delivery of the service.
2. The provider agency's clients have on file with the department a current person-centered service plan.
3. The provider agency has a current valid provider agency agreement with the department authorizing the payment.
4. The provider agency adopts and uses a system of accounting prescribed by the department.
5. The provider agency participates in the program audit and utilization review process established by the department.
6. The provider agency is in compliance with all documentation requirements in chapter 75-04-01.
7. Provider agency, as a condition of eligibility for payment for services provided to individuals with developmental disabilities, shall accept, as payment in full, sums paid in accordance with the established rate of payment.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-03. Startup costs.

Repealed effective June 1, 1995.

75-04-05-04. Application for advancement of startup costs.

Repealed effective June 1, 1995.

75-04-05-05. Allowable startup costs.

Repealed effective June 1, 1995.

75-04-05-06. Reimbursement requirements - Startup costs.

Repealed effective June 1, 1995.

75-04-05-07. Grants-in-aid.

Repealed effective June 1, 1995.

75-04-05-08. Financial reporting requirements.

1. **Records.**

a. The provider agency shall maintain on the premises the required census records and financial information sufficient to provide for a proper state and federal audit or review. Data must be available for any cost on the statement of costs as of the audit date to fully support the statement item.

b. If several programs are associated with a group and their accounting and reports are centrally prepared, additional fiscal information must be submitted for costs, undocumented at the reporting facility, with the statement of costs or provided prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

c. Each provider agency shall maintain, for a period of not less than six years following the date of submission of the statement of costs to the department, financial and statistical records of the period covered by such statement of costs which are accurate and in sufficient detail to substantiate the cost data reported. If an audit has begun, but has not been finally resolved, the financial and statutory records relating to the audit must be retained until final resolution. Each provider agency shall make such records available upon reasonable demand to representatives of the department or to the secretary of health and human services or representatives thereof.

2. **Census records.**

a. Adequate census records for all clients, regardless of payer source, must be prepared and maintained on a daily basis by the provider agency to allow for proper audit of the census data. The daily census records must include:

(1) Identification of the client;

(2) Entries for all days that services are offered, including the duration of service, and not just by exception; and

(3) Identification of type of day, i.e., hospital or in-house day.

b. A maximum of fifteen days per occurrence may be allowed for payment by the medical assistance program for hospital leave day in an intermediate care facility for individuals with intellectual disabilities. Hospital leave days in excess of fifteen consecutive days are not billable to the medical assistance program.

c. A maximum of thirty therapeutic leave days per client per calendar year may be allowed for payment by the medical assistance program in an intermediate care facility for individuals with intellectual disabilities. Therapeutic leave days in excess of thirty per calendar year are not billable to the medical assistance program.

3. **Accounting and reporting requirements.**

a. The accounting system must be double entry.

b. The basis of accounting for reporting purposes must be accrual in accordance with generally accepted accounting principles. Ratesetting procedures will prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles.

c. To properly facilitate auditing, the accounting system must be maintained in a manner that will allow cost accounts to be grouped by cost center and readily traceable to the statement of costs.

d. A provider agency who offers intermediate care facility for individuals with intellectual disability services may have an independent certified public accountant or the

department complete an audit of the provider agency during the statement of costs year of each year to ensure the provider agency is in compliance with applicable state and federal regulations.

e. For each provider agency that chose to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed by the department.

(2) A copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs and must include:

(a) A statement of assets and liabilities;

(b) An operations statement;

(c) A statement disclosing contract income and client wages;

(d) A statement of client fees or payments and their distribution, including private pay individuals;

(e) A statement of the assets and liabilities of any related organizations;

(f) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

[1] If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

[2] If a publicly held corporation has an ownership interest of fifteen percent or more in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of fifteen percent or more;

(g) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(h) Supplemental information reconciling the costs on the financial statements with costs on the statement of costs; and

(i) Independent audit report must comply with this chapter and follow:

[1] Medicare and Medicaid guidance and provider payment manual;

[2] Government auditing standards;

[3] North Dakota Century Code chapters 25-01.2 and 25-04;

[4] Titles 2, 42, and 45, Code of Federal Regulations, American institution of certified public accountants, financial accounting standards board, and government accounting standards board rules and regulations; and

[5] All other applicable state and federal regulations.

(3) The following information upon request by the department:

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

(b) Audited financial statements for any home or corporate office organization, excluding individual developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

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

f. For each provider agency that chose not to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed by the department;

(2) Except for state-owned facilities and provider agencies that do not have an independent audit completed annually, a copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs;

(3) A statement of assets and liabilities;

(4) An operations statement;

(5) A statement disclosing contract income and client wages;

(6) A statement of client fees or payments and their distribution, including private pay individuals;

(7) A statement of the assets and liabilities of any related organizations;

(8) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

(a) If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in

the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

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

(9) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(10) Supplemental information reconciling the costs on the financial statements with costs on the statement of costs; and

(11) The following information upon request by the department:

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

(b) Audited financial statements for any home or corporate office organization, excluding individual developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

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

g. A statement of costs must contain the actual costs, adjustments for nonallowable costs, and units of service. The mailing of a statement of costs by registered mail, return receipt requested, ensures documentation of the filing date.

h. Adjustments made by the audit unit, to determine allowable cost, though not meeting the criteria of fraud or abuse on their initial identification, may, if repeated on future cost filings, be considered as possible fraud or abuse.

i. The provider agency shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any statement of costs when the information filed is incomplete or inaccurate. If a statement of costs is rejected, the department may reduce the current payment rate to ninety-five percent of its most recently established rate until the information is completely and accurately filed.

4. **Auditing.** In order to properly validate the accuracy and reasonableness of cost information reported by the provider agency, the department shall provide for audits as necessary.

a. A provider agency shall submit its statement of costs by October first of the statement of cost year.

b. A provider agency may request, and the department may grant, one thirty-day extension of the due date of the statement of costs for good cause.

(1) If a provider agency fails to file the required statement of costs on or before the due date, the department may reduce the current payment rate to ninety-five percent of its most recently established rate.

(2) Reinstatement of the rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

c. The preliminary audit report shall be submitted to the provider agency no later than six months after the department receives the provider agency's statement of costs. The provider agency must be notified by facsimile transmission or electronic mail.

d. The provider agency may submit information, within thirty days after notification, to explain why the provider agency believes the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

e. The final audit report shall be submitted to the provider agency within sixty days of the department's receipt of the provider agency's response.

f. Provider agency shall submit requests for information and responses to the department in writing. In computing any period of time prescribed or allowed in this subsection, the day of the act, event, or default from which the designated period of time begins to run may not be included. The last day of the period so computed must be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. In determining whether the deadlines described in subdivision c, d, or e have been met, the department may not count any day that sufficient information has not been timely provided by a provider agency when the provider agency has shown good cause for its inability to provide the required information within the time periods prescribed in any one of those subdivisions.

5. **Penalties for false reports**.

a. A false report is when a provider agency knowingly supplies inaccurate or false information in a required statement of costs and supporting documentation that results in inaccurate costs.

b. If a false report is received, the department may:

(1) Place the provider agency's license on restricted status as defined in chapter 75-04-01;

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

(3) Refer to law enforcement for investigation and prosecution under applicable state or federal law; or

(4) Use any combination of the foregoing actions.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; August 1, 1997; July 1, 2001; May 1, 2006; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-09. Rate payments.

1. The direct care hourly rate and components for each service are issued in a rate matrix established by the department. The components are:

a. The direct care hourly rate for intermediate care facilities for individuals with developmental disabilities must include direct care wage, employment-related costs, relief staff, administrative cost, and program support, including room and board. Building depreciation and related interest costs will be calculated either by an established percentage, or if a facility is acquired or built after January 1, 2010, the provider agency may choose the actual building depreciation and related interest costs relating to the facility for the life of the building to be added to the rate. For facilities acquired after January 1, 2010, subdivision c of subsection 3 of section 75-04-05-15 must be followed in determining remaining useful life. After the depreciable life is complete the established percentage for building depreciation and related interest costs will be utilized.

b. The direct care hourly rate for residential habilitation must include direct care wage, employment-related expenses, relief staff, program support, administrative costs, and an absence factor.

c. The direct care hourly rate for independent habilitation, day habilitation, prevocational services, individual employment supports, and small group employment supports must include direct care wage, employment-related expenses, relief staff, program support, and administrative costs.

d. The direct care hourly rate for in-home supports and parenting supports must include direct care wage, employment-related expenses, program support, and administrative costs.

2. For residential habilitation, independent habilitation, day habilitation, prevocational services, and employment supports, the maximum authorized assessment score hours for a client are:

   a. For each of the above services the established payment must be calculated by multiplying the rate from the rate matrix times the hours identified by the multiplier based on the client's assessment score from the standard assessment tool, except for residential services provided in an intermediate care facility for individuals with intellectual disabilities, for which the established rate shall be the sum of all services identified for the client. A provider may request and the department may grant an outlier request for clients who have needs exceeding the client's assessment score.

   b. Self-directed services or provider agency directed in-home supports do not require prior authorization based on the assessment score. Hours must be estimated by the program manager based on the person-centered services planning process with input from the client and the client-authorized representative, if applicable. These services are subject to the maximum annual hours as prescribed by the department.

3. Base staffing rate:

   a. A provider agency may receive a base staffing rate when opening a new licensed group home or intermediate care facility for individuals with intellectual disabilities, including prior to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] certification and survey requirements.

   b. A base staffing rate must be calculated based on minimum required staffing levels identified by the department.

   c. A base staffing rate is effective for an intermediate care facility for individuals with intellectual disabilities on the date it is licensed by the department.

   d. A provider agency shall receive a base staffing rate until the setting is fully occupied, or for three months, whichever comes first.

4. Vacancy:

   a. A residential habilitation provider agency or intermediate care facility for individuals with intellectual disabilities may receive a vacancy rate add-on in the event of a vacancy.

   b. A provider agency shall request the vacancy rate add-on within fifteen days of the vacancy.

   c. A vacancy rate add-on is available only for residential habilitation or intermediate care facilities for individuals with intellectual disabilities.

   d. The vacancy rate add-on is calculated using the rate of the client who vacated the setting. The vacancy rate add-on is evenly applied to all other client rates in the setting.

   e. A provider agency shall receive a vacancy rate add-on until the vacancy is filled, but shall not exceed three months.

5. Room and board charges to clients may not exceed the maximum supplemental security income payment less one hundred dollars for the personal incidental costs of the client, plus the average dollar value of supplemental nutrition assistance program to the eligible clientele in the facility.

6. In residential facilities where rental assistance is available to individual clients or the facility, the rate for room costs chargeable to individual clients are established by the governmental unit providing the subsidy.

7. In residential facilities where energy assistance program benefits are available to individual clients or the facility, room and board rates are reduced to reflect the average annual dollar value of such benefits.

8. Income from client production must be applied to client wages and the cost of production. The department will not participate in the gains or losses associated with client production conducted pursuant to the applicable provision of title 29, Code of Federal Regulations, part 525.

9. A provider agency may not solicit or receive a payment from a client or any other individual to supplement the established rate of payment.

10. The rate of payment established must be no greater than the rate charged to a private payor for the same or similar service.

11. Limitations:

    a. The department shall accumulate and analyze statistics on costs incurred by provider agencies. Statistics may be used to establish reasonable ceiling limitations for needed services. Limitations may be established on the basis of cost of comparable facilities and services, or audited costs, and may be applied as ceilings on the overall costs, on the costs of providing services, or on the costs of specific areas of operations. The department may implement ceilings at any time, based upon the statistics available, or as required by guidelines, regulations, rules, or statutes.

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

the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under Medicare payment principles.

c. Provider agencies may not be reimbursed for services, rendered to a client, which exceed the rated occupancy of any facility as established by a fire prevention authority.

d. Provider agencies of residential services shall offer services to each client three hundred sixty-five days per year, except for leap years in which three hundred sixty-six days must be offered. Provider agencies may not be reimbursed for those days in which services are not offered to a client.

e. Provider agencies of day services shall offer services to each client eight hours per day two hundred sixty days per year, except leap years in which two hundred sixty-one days must be offered, less any state-recognized holidays, unless a holiday exception is approved by the department. Provider agencies may not be reimbursed for hours of service in which the client is not in attendance.

f. Provider agencies of day services to clients of intermediate care facilities for individuals with intellectual disabilities shall bill the intermediate care facility for individuals with intellectual disabilities the day habilitation rate established for the client.

12. Adjustments and review procedures are as follows:

a. Adjustments may be made to correct errors. Statement of costs must be reviewed taking into consideration prior years' adjustments. The provider agency must be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. A provider agency may submit information, within thirty days after notification, to explain why the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

b. A provider agency may submit a request for reconsideration of the final statement of costs review in writing to the developmental disabilities division within fifteen days of the date of the final statement of costs review notification. A request for reconsideration must provide new evidence indicating why a new determination should be made or explain how the department has incorrectly interpreted the law. The department shall respond to a properly submitted request for reconsideration within ninety days of receipt of the request. The department may revise the final statement of costs review on its own motion.

c. A provider agency may appeal the decision within thirty days after the department mails the written notice of the decision on a request for reconsideration of the final review of the statement of costs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996; August 1, 1997; July 1, 2001; May 1, 2006; July 1, 2012; January 1, 2013; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-09.1. Assessments.

1. An assessment must be completed within ninety days or at the time there are sufficient qualified responders, for a client who has been determined eligible to receive developmental disabilities services and is receiving a service that requires an assessment score to determine payment. The assessment effective date is the first date the client began receiving a service.

2. A reassessment must be completed every thirty-six months for a client aged sixteen or older or every twelve months for a client under age sixteen, or more frequently if a life-changing event occurs.

    a. A reassessment based on a life-changing event may be requested by a client, a client-authorized representative, or an employee of a provider agency. Requests for reassessment must be made in writing to the appropriate department regional office.

    b. The assessment effective date is reset upon completion of a reassessment as a result of a life-changing event.

History: Effective April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-10. Cost centers.

The cost centers where direct and indirect costs are allocated on a provider agency's statement of costs may include:

1. Administration.

2. Indirect program support costs.

3. Provider agency shall disclose to the department direct care costs for staff that provide direct care and nursing services separately for the annual statement of costs. Costs shall only include:

    a. Direct care staff salaries and fringe benefits; and

    b. Contracted costs for services purchased to actively provide support to clients receiving a service from a provider agency.

4. Direct program support costs.

5. Room.

6. Board.

7. Other costs and production.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996; July 1, 2001; July 1, 2010; July 1, 2012; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-11. Statement of costs allocations.

The statement of costs provides for the identification of the allowable expenditures and basic services subject to payment by the department. When costs are incurred solely for a basic service, the costs must be assigned directly to that basic service. When costs are incurred jointly for two or more basic services, and not able to be directly assigned, the costs must be allocated as follows:

1. Personnel. The total cost of all staff identified in payroll records must be listed by position title and distributed to basic services. Time studies may be performed for one week at least quarterly for allocation. When no time studies exist, the applicable units must be used for allocation. When there is no definition of a unit of service, the department must use the unit of service for billing purposes for residential settings.

2. Fringe benefits. The cost of fringe benefits must be allocated to basic services based on the ratio of the basic service personnel costs to total personnel costs. Personnel costs on which no fringe benefits are paid are excluded.

3. Equipment. The total cost of all equipment, whether rented, leased, purchased, or depreciated, must be distributed to basic services based on usage or applicable units.

4. Real property cost. The total of all property costs, whether rented, leased, purchased, or depreciated, must be allocated based on direct square footage. When multiple usage of direct use area occurs, the allocation is first done by square footage and then by applicable units.

5. Travel. The total of all unassigned travel costs must be included in administrative costs.

6. Supplies. The total of all unassigned supply costs must be included with administrative costs.

7. Food services. The total of all food costs must be allocated based on meals served. When the number of meals served has not been identified, applicable units must be used.

8. Insurance and bonds. The total of all such costs, except insurance costs representing real property costs or vehicle insurance costs applicable to vehicles used for one or more basic services, must be included as administrative costs.

9. Indirect program support costs. Total indirect program support costs, not including personnel and fringe benefits, must be allocated to basic service categories, exclusive of production, room, and board, based on actual units of service. When determining the day habilitative ratio of indirect program support costs, total day habilitation units are divided by thirty-two and rounded to the nearest whole number.

10. Administrative costs. Total administrative costs must be allocated to all service categories, exclusive of residential habilitation room, board, and production, based upon the ratio of the basic service cost to total cost excluding administrative and production costs. The percentage calculated for habilitation services must be based on total costs, including room and board, with the allocation made only to direct care costs, direct program support costs, and indirect program support costs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; May 1, 2006; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-12. Adjustment to cost and cost limitation.

1. Provider agencies under contract with the department to provide services to individuals with developmental disabilities who provide intermediate care facilities for individuals with intellectual disabilities shall submit a statement of costs to the department by October first of each year.

2. Provider agencies shall disclose all costs and all revenues.

3. Provider agencies shall identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. Income must be offset up to the total of appropriate allowable costs. If actual costs are not identifiable, income must be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. These sources, and the cost to be offset, must include the following:

a. Fees, the cost of the service or time for which the fee was imposed excluding those fees based on cost as established by the department.

b. Insurance recoveries income, costs reported in the current year to the extent of costs allowed in the prior or current year for that loss.

c. Rental income, cost of space in facilities or for equipment included in the rate of payment.

d. Telephone and internet income from clients, staff, or guests, cost of the service.

e. Rental assistance or subsidy when not reported as third-party income, total costs.

f. Interest or investment income, interest expense.

g. Medical payments, cost of medical services included in the rate of payment as appropriate.

h. Respite care income when received for a reserved bed, room, board, and staff costs.

i. Other income to the provider agency from local, state, or federal units of government may be determined by the department to be an offset to cost.

4. Payments to a provider agency by its vendor are considered as discounts, refunds, or rebates in determining allowable costs under the program even though these payments may be treated as "contributions" or "unrestricted grants" by the provider agency and the vendor. However, such payments may represent a true donation or grant, and as such may not be offset against costs. Examples include when:

   a. Payments are made by a vendor in response to building or other fundraising campaigns in which communitywide contributions are solicited.

   b. Payments are in addition to discounts, refunds, or rebates, which have been customarily allowed under arrangements between the provider agency and the vendor.

   c. The volume or value of purchases is so nominal that no relationship to the contribution can be inferred.

   d. The contributor is not engaged in business with the provider agency or a facility related to the provider agency.

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

6. If the purchasing function for a provider agency is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to the costs of the provider agency in accordance with the instructions above. These may not be treated as income of the central purchasing function or used to reduce the administrative costs of that function. Such administrative costs are, however, properly allocable to the facilities serviced by the central purchasing function.

7. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased. They must be used to reduce the specific costs to which they apply. If possible, they must accrue to the period to which they apply. If not, they will reduce costs in the period in which they are received. The reduction to cost for supplies or services must be

used to reduce the total cost of the goods or services for all clients without regard to whether the goods or supplies are designated for all clients or a specific group.

a. "Purchase discounts" include cash discounts, trade, and quantity discounts. "Cash discount" is for prepaying or paying within a certain time of receipt of invoice. "Trade discount" is a reduction of cost granted certain customers. "Quantity discounts" are reductions of price because of the size of the order.

b. Allowances are reductions granted or accepted by the creditor for damage, delay, shortage, imperfection, or other cause, excluding discounts and refunds.

c. Refunds are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or return purchases.

d. Rebates represent refunds of a part of the cost of goods or services. Rebates differ from quantity discounts in that they are based on the dollar value of purchases, not the quantity of purchases.

e. "Other cost-related income" includes amounts generated through the sale of a previously expensed item, e.g., supplies or equipment.

History: Effective July 1, 1984; amended effective June 1, 1995; July 1, 2001; May 1, 2006; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-13. Nonallowable costs.

Nonallowable costs include:

1. Advertising designed to encourage potential clients to select a particular provider agency.

2. Amortization of noncompetitive agreements.

3. Bad debt expense.

4. Barber and beautician services.

5. Basic research.

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

7. Concession and vending machine costs.

8. Contributions or charitable donations.

9. Corporate costs, such as organization costs, reorganization costs, and other costs not related to client services.

10. Costs for which payment is available from another primary third-party payor or for which the department determines that payment may lawfully be demanded from any source.

11. Costs of functions performed by clients in a residential setting which are typical of functions of any individual living in the individual's own home, such as keeping the home sanitary, performing ordinary chores, lawnmowing, laundry, cooking, and dishwashing. These activities

shall be an integral element of an individual program plan consistent with the client's level of function.

12. Costs of donations or memberships in sports, health, fraternal, or social clubs or organizations, such as Elks, YMCA, or country clubs.

13. Costs, including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to the vendor.

14. Costs incurred by the provider agency's subcontractors, or by the lessor of property which the provider agency leases, and which becomes an element in the subcontractor's or lessor's charge to the provider agency, if such costs would not have been allowable under this section had they been incurred by a provider agency directly furnishing the subcontracted services, or owning the leased property.

15. Depreciation on assets acquired with federal or state grants.

16. Education costs incurred for the provision of services to clients who are, could be, or could have been, included in a student census. Education costs do not include costs incurred for a client, defined as a "student with disabilities" by North Dakota Century Code chapter 15.1-32, who is enrolled in a school district pursuant to an interdepartmental plan of transition.

17. Employee benefits not offered to all full-time employees.

18. Entertainment costs, including activities.

19. Equipment costs for any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates to the satisfaction of the department that any particular use of the equipment was related to client services.

20. Expense or liabilities established through or under threat of litigation against the state of North Dakota or any of its agencies; provided, that reasonable insurance expense may not be limited by this subsection.

21. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, such as Lions, chamber of commerce, Kiwanis, in excess of one thousand five hundred dollars per statement of costs period.

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

23. Funeral and cemetery costs.

24. Goodwill.

25. Home office costs when unallowable if incurred by facilities in a chain organization.

26. Travel not directly related to industry conferences, state or federally sponsored activities, or client services.

27. Interest cost related to money borrowed for funding depreciation.

28. Items or services, such as telephone, television, and radio, located in a client's room and furnished primarily for the convenience of the clients.

29. Top management personnel insurance.

30. Laboratory salaries and supplies.

31. The cost of education unless:

    a. The education was provided by an accredited academic or technical educational facility;

    b. The costs were for materials, books, or tuition;

    c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility and is in a position; and

    d. The facility claims the cost of the education at a rate that does not exceed one dollar and twenty-five cents per hour of work performed by the employee in the position for which the employee received education at the provider agency's cost provided the amount claimed per employee may not exceed two thousand five hundred dollars per year or an aggregate of ten thousand dollars per employee and in any event may not exceed the cost to the facility of the employee's education.

32. Meals and food service in day service programs.

33. Membership fees or dues for professional organizations exceeding six thousand dollars in any statement of costs year.

34. Materials and monetary reinforces for clients.

35. Miscellaneous costs not related to client services.

36. a. Except as provided in subdivisions b, c, and d, payments to a member of the governing board of the provider agency, a member of the governing board of a related organization, or a family member of a member of those governing boards, including a spouse and an individual in the following relationship to a member or to a spouse of a member: parent, stepparent, child, stepchild, grandparent, step-grandparent, grandchild, step-grandchild, brother, sister, half-brother, half-sister, stepbrother, and stepsister.

    b. Payments made to a member of the governing board of the provider agency to reimburse that member for allowable costs incurred by that member in the conduct of the provider agency's business may be allowed.

    c. Payments for a service or product unavailable from another source at a lower cost may be allowed.

    d. Wages allowed are limited to those wages paid to a family member of a member of the board and the amount must be consistent with wages paid to anyone else who would hold the same or similar position and the position is such that if the family member were not to hold the position agency, the provider would hire someone else to do the job.

37. Penalties, fines, and related interest and bank charges other than regular service charges.

38. Personal purchases.

39. Pharmacy salaries.

40. Physician and dentist salaries.

41. a. For facility-based day habilitation programs, production costs, such as client salaries and benefits, supplies, and materials representing unfinished or finished goods or products that are assembled, altered, or modified.

b. For non-facility-based day habilitation programs, production costs, such as client salaries and benefits, supplies, and materials representing unfinished or finished goods or products that are assembled, altered, or modified, square footage, and equipment.

c. For employment supports, in addition to subdivisions a and b, costs of employing clients, including preproduction and postproduction costs for supplies, materials, property, and equipment, and property costs other than an office, office supplies, and equipment for the supervisor, job coach, and support staff.

d. Total production-related legal fees in excess of five thousand dollars in any fiscal period.

42. Religious salaries, space, and supplies.

43. Room and board costs in residential services other than an intermediate care facility for individuals with intellectual disabilities.

44. Salary costs of employees determined by the department to be inadequately trained to assume assigned responsibilities, but when an election has been made to not participate in appropriate training approved by the department.

45. Salary costs of employees who fail to meet the functional competency standards established or approved by the department.

46. Travel of clients visiting relatives or acquaintances in or out of state.

47. Mileage reimbursement in excess of the standard mileage rate established by the state of North Dakota and meal reimbursement in excess of rates established by the general services administration for the destination city.

48. Undocumented expenditures.

49. Value of donated goods or services.

50. Vehicle and aircraft costs not directly related to provider agency business or client services.

51. X-ray salaries and supplies.

52. Alcohol and tobacco products.

53. Political contributions.

54. Salaries or costs of a lobbyist.

History: Effective July 1, 1984; amended effective June 1, 1985; January 1, 1989; August 1, 1992; June 1, 1995; July 1, 1995; April 1, 1996; August 1, 1997; July 1, 2001; May 1, 2006; July 1, 2012; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-13.1. Allowable bad debt expense.

1. Bad debts for charges incurred in or after July 1, 2005, and fees paid for the collections of those bad debts are allowable only as provided in this section.

2. A bad debt expense must result from nonpayment of the payment rate for an individual who is no longer receiving services from the provider claiming the bad debt expense.

3. The provider must provide documentation to the department which verifies that the provider made reasonable collection efforts, the debt could not be collected, and there is no likelihood

of future recovery. Reasonable collection efforts include maintaining written documentation that, in making those collection efforts, the provider received the assistance of an attorney licensed to practice law.

4. In no circumstance may the allowable expense for the collection fee exceed the amount of the bad debt.

5. A bad debt expense shall not be allowed when it resulted from the provider's failure to comply with any applicable laws or regulations.

6. Before any bad debt expense may be allowed, the provider must have a written policy that limits the potential for bad debts and the provider must provide written documentation that shows it has taken action to limit bad debts for individuals who refuse to or cannot make payments.

7. Allowable bad debt expense may not exceed debt associated with one hundred twenty days of services provided for any one individual.

8. Payments on outstanding accounts receivable shall be applied to the oldest invoices for covered services first, and then all subsequent charges until the balance is paid in full.

9. Allowable finance charges on bad debts described in this section are allowable only if the finance charges have been offset as interest income.

History: Effective May 1, 2006.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-16-10, 50-24.1-01

75-04-05-14. Profit-motivated entities - Return on investment.

Repealed effective April 1, 2018.

75-04-05-15. Depreciation.

1. The principles of payment for provider agency costs require that payment for services include depreciation on depreciable assets that are used to provide allowable services to clients. This includes assets that may have been fully or partially depreciated on the books of the provider agency, but are in use at the time the provider agency enters the program. The useful lives of these assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. Depreciation is recognized as an allocation of the cost of an asset over its estimated useful life. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the statement of costs. The facility shall use the sale price in computing the gain or loss on the disposition of assets.

2. Special assessments in excess of one thousand dollars paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as billed by the taxing authority.

3. Depreciation methods:

    a. A provider agency shall use the straight-line method of depreciation. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, may not be

used. A provider agency shall apply the method and procedure for computing depreciation on a basis consistent from year to year and shall maintain detailed schedules of individual assets. If the books of account reflect depreciation different than that submitted on the statement of costs, a provider agency shall prepare a reconciliation.

b. For all assets obtained prior to August 1, 1997, a provider agency shall compute depreciation using a useful life of ten years for all items except vehicles, which must be depreciated over four years, and buildings, which must be depreciated over twenty-five years or more. For assets other than vehicles and buildings obtained after August 1, 1997, a provider agency may use the depreciation guidelines, to determine the useful life or the composite useful life of ten years. For all assets, other than vehicles and buildings, obtained prior to April 1, 2018, a provider agency's prior depreciation schedule must be used. A provider agency shall use a useful life of ten years for all equipment not identified in the depreciation guidelines.

c. A provider agency acquiring assets as an ongoing operation shall use as a basis for determining depreciation:

(1) The estimated remaining life, as determined by a qualified appraiser, for land improvements, buildings, and fixed equipment; and

(2) (a) A composite remaining useful life for movable equipment, determined from the seller's records; or

(b) The remaining useful life for movable equipment, determined from the seller's records.

4. Acquisitions are treated as follows:

a. If a depreciable asset has, at the time of its acquisition, a historical cost of at least five thousand dollars, its cost must be capitalized and depreciated in accordance with subdivision b of subsection 3. A provider agency shall capitalize as part of the cost of the asset, costs incurred during the construction of an asset, such as architectural, consulting and legal fees, and interest.

b. A provider agency shall capitalize major repair and maintenance costs on equipment or buildings if they exceed five thousand dollars per project and will be depreciated in accordance with subdivision b of subsection 3.

5. A provider agency shall maintain records that provide accountability for the capital assets and other assets and also provide adequate means by which depreciation can be computed and established as an allowable client-related cost.

6. The basis for depreciation is the lower of the purchase price or fair market value at the time of purchase.

If the provider agency's cash payment for a purchase is reduced by a trade-in, fair market value will consist of the sum of the book value of the trade-in plus the cash paid.

7. For depreciation and payment purposes, a provider agency may record and depreciate donated depreciable assets based on the asset's fair market value. If the provider agency's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal must be made. An appraisal made by a recognized appraisal expert will be accepted for depreciation.

8. Provision for increased costs due to the sale of a facility may not be made.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; August 1, 1997; July 1, 2001; May 1, 2004; May 1, 2006; January 1, 2013; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-16. Interest expense.

1. In general:

   a. To be allowable under the program, interest must be:

      (1) Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required;

      (2) Identifiable in the provider agency's accounting records;

      (3) Related to the reporting period in which the costs are incurred;

      (4) Necessary and proper for the operation, maintenance, or acquisition of the provider agency's facilities used therein;

      (5) Unrelated to funds borrowed to purchase assets in excess of cost or fair market value; and

      (6) When borrowed for the purpose of making capital expenditures for assets that were owned by any other facility or service provider agency on or after July 18, 1984, limited to that amount of interest cost which such facility or service provider agency may have reported, had the asset undergone neither refinancing nor a change of ownership.

   b. In cases when it was necessary to issue bonds for financing, any bond premium or discount must be accounted for and written off over the life of the bond issue.

2. Interest paid by the provider agency to partners, stockholders, or related organizations of the provider agency is not allowable as a cost.

3. A provider agency may combine or "pool" various funds in order to maximize the return on investment. If funds are pooled, proper records must be maintained to preserve the identity of each fund in order to permit the earned income to be related to its source. Income earned on gifts and grants does not reduce allowable interest expense.

4. Funded depreciation requirements are as follows:

   a. Funding of depreciation is the practice of setting aside cash or other liquid assets to be used for replacement of the assets depreciated or for other capital purposes. This provision is recommended as a means of conserving funds for the replacement of depreciable assets. It is expected that the funds will be invested to earn revenues. The revenues generated by this investment will not be considered as a reduction of allowable interest expense provided such revenues remain in the fund.

   b. The deposits are, in effect, made from the cash generated by the noncash expense depreciation and do not include interest income. Deposits to the funded depreciation account are generally in an amount equal to the depreciation expense charged to costs each year. In order to qualify for all provisions of funding depreciation, the minimum deposits to the account must be fifty percent of the depreciation expensed that year. Deposits in excess of accumulated depreciation are allowable; however, the interest

income generated by the "extra" deposits will be considered as a reduction of allowable interest expense.

c. Monthly or annual deposits representing depreciation must be in the funded depreciation account for six months or more to be considered as valid funding transactions. Deposits of less than six months are not eligible for the benefits of a funded depreciation account. However, if deposits invested before the six-month period remain in the account after the six-month period, the investment income for the entire period will not reduce the allowable interest expensed in that period. Total funded depreciation in excess of accumulated depreciation on client-related assets will be considered as ordinary investments and the income therefrom will be used to offset interest expense.

d. Withdrawals for the acquisition of capital assets, the payment of mortgage principal on these assets and for other capital expenditures are on a first-in, first-out basis.

e. The provider agency may not use the funds in the funded depreciation account for purposes other than the improvement, replacement, or expansion of facilities or equipment replacement or acquisition related to client services.

f. Existing funded depreciation accounts must be used for all capital outlays in excess of five thousand dollars except with regard to those assets purchased exclusively with donated funds or from the operating fund, provided no amount was borrowed to complete the purchase. Should funds be borrowed, or other provisions not be met, the entire interest for the funded depreciation income account will be offset up to the entire interest expense paid by the facility for the year in question.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; January 1, 2013; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-17. Related organization.

1. Costs applicable to services, facilities, and supplies furnished to a provider agency by a related organization shall not exceed the lower of the cost to the related organization or the reasonable costs of services, facilities, or supplies purchased elsewhere. Provider agencies shall identify such related organizations and costs in the statement of costs. An appropriate statement of cost and allocations must be submitted with the statement of costs. For statement of costs purposes, management fees are considered administrative costs.

2. A chain organization consists of a group of two or more service provider agencies which are owned, leased, or through any other device, controlled by one business entity.

3. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a provider agency in itself, it may furnish to the individual provider agency, central administration or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services is includable in the provider agency's allowable costs under the program. Any services provided by the home office which are included in cost as payments to an outside provider agency will be considered a duplication of costs and not be allowed.

4. If the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.

5. Payments, to related organizations, by the provider agency are limited to the actual and reasonable cost of the service received or the product purchased.

6. Provider agency shall document financial transactions between the provider agency and the related organization. The terms of such transactions must be similar as those obtained by a prudent buyer negotiating at arm's length with a willing and knowledgeable seller.

History: Effective July 1, 1984; amended effective June 1, 1985; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-18. Rental expense paid to a related organization.

1. A provider agency may lease a facility from a related organization within the meaning of the principles of payment. In such a case, the rent paid to the lessor by the provider agency is not allowable as a cost. Provider agency's rent payments shall not exceed the actual cost of mortgage payments of principal and interest. The cost of ownership of the facility would, however, be an allowable cost to the provider agency. Generally, these would be costs such as depreciation, interest on the mortgage, real estate taxes, and other property expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider agency. Therefore, the owner's equity in the leased assets is includable in the equity capital of the provider agency.

2. In order to be considered an allowable cost, the home office cost must be directly related to those services performed for individual provider agencies and relate to client services. Documentation as to the time spent, the services provided, the hourly valuation of services, and the allocation method used must be available to substantiate the reasonableness of the cost.

History: Effective July 1, 1984; amended effective June 1, 1985; April1 , 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-19. Taxes.

1. **General.** Taxes assessed against the provider agency, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax costs may not include fines, penalties, or those taxes listed in subsection 2.

2. **Taxes not allowable as costs.** The following taxes are not allowable as costs:

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

   b. State or local income and excess profit taxes.

   c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfers of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

   d. Taxes from which exemptions are available to the provider agency.

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

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

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

History: Effective July 1, 1984; amended effective July 1, 2001; May 1, 2006; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-20. Personal incidental funds.

1. Each client is allowed to retain a specific monthly amount of income for personal needs. This monthly allowance is not to be applied toward the client's cost of care.

2. Provider agencies managing client funds must maintain a current client account record in a form and manner prescribed by the department. Copies of the client account record must be provided to the client without charge.

3. The department may conduct audits of client account records in conjunction with regular field audits.

4. Adult client funds may be disbursed with the client's permission in the absence of a client-authorized representative or declaration of incompetency.

5. The department uses the amount of a client's income to determine:

   a. Eligibility for medical assistance benefits.

   b. Amount of income and other resources which must be applied toward the client's care.

   c. Amount of income and other resources which can be retained by the client.

6. Personal incidental items, supplies, or services furnished as needed or at the request of the client may be paid for by the client from the client's personal incidental allowance or by outside sources, such as relatives and friends.

7. Charges by the program for items or services furnished clients will be allowed as a charge against the client or outside sources, only if separate charges are also recorded by the facility for all clients receiving these items or services directly from the program. All such charges must be for direct, identifiable services or supplies furnished individual clients. A periodic "flat" charge for routine items, such as beverages, incidentals, etc., will not be allowed. Charges may be made only after services are performed or items are delivered, and charges are not to exceed charges to all classes of clients for similar services.

8. A client's private property must be clearly marked by name. The facility must keep a record of private property. If items are lost, the circumstances of disappearance must be documented in the facility's records.

9. If client funds are deposited in a bank, they must be deposited in an account separate and apart from any other bank accounts of the facility. Any interest earned on this account will be credited to the applicable client's accounts.

10. A client's funds on deposit with the facility must be available to a client on the client's request. No funds may be withdrawn from accounts of a client capable of managing the client's own funds without the client's permission.

11. Should a disagreement exist as to whether a client is capable of managing the client's own funds, a joint determination will be made by the person-centered service plan team and client-authorized representative in settling this dispute. The decision must be documented in the provider agency's records and the client's person-centered service plan.

12. On discharge, the facility must provide the client with a final accounting of personal funds and remit any balance on deposit with the facility.

13. Upon death, the balance of a client's personal incidental funds along with the name and case number, must be maintained in an interest-bearing account for disposition by the client's estate. Personal property, such as television sets, radios, wheelchairs, and other property of more than nominal value, must be maintained for disposition by the client's estate.

14. Upon sale or other transfer of ownership interest of a facility, both transferor and transferee must transfer the client's personal incidental funds, moneys, and records in an orderly manner.

15. Failure to properly record the receipt and disposition of personal incidental funds may constitute grounds for suspension of provider agency payments.

16. Client personal incidental funds must not be expended by the provider agency for the purchases of meals served in licensed day habilitation, employment support, and prevocational services nor may the purchase of such meals be a condition for admission to such programs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; July 1, 2012; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-21. Transfer, discharge, and expulsion of clients.

1. Movement of clients between levels of service by a provider agency or between provider agencies must be pursuant to a determination by the person-centered service plan team. Payment for the cost of a new service is contingent upon the timely submission to the department of a person-centered service plan.

2. Movement of clients are subject to the policies and procedures of the North Dakota program management system and the approval of the department.

3. Any emergency movement may be initiated by the provider agency only with immediate notification of the department, client, and client-authorized representative. The movement is subject to subsequent review by the department which will determine if:

   a. An emergency existed;

   b. The rights of the client were protected and preserved;

   c. Documentation exists in support of the provider agency's action;

   d. A prognosis of the client's potential for returning has been made; and

   e. Services required to maintain the client in a habilitative setting are least restrictive and have been provided prior to movement.

4. The department will determine whether a payment should be stopped as a consequence of the vacancy caused by movement of a client.

5. Upon a finding, by the department, that movement of a client constituted a violation of any right secured to the client by North Dakota Century Code chapter 25-01.2, the department may withhold payment for services provided during the period of time that the violation existed.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; April 1, 2018.

General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-22. Staff-to-client ratios.

The overall direct contact staff-to-client ratios shall form the basis for the determination of the rate of payment for provider agencies of service to individuals with intellectual or developmental disabilities. Additional staff may be necessary to meet the needs of the clients and may be added subject to the approval of the department.

Intermediate care facilities for individuals with intellectual disabilities are subject to the direct contact staffing requirements of title 42, Code of Federal Regulations, part 483, section 430.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; July 1, 2010; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-23. Staff hours.

Repealed effective April 1, 2018.

75-04-05-24. Application.

This chapter will be applied to provider agencies for services to individuals with developmental disabilities, except distinct parts of state institutions for individuals with developmental disabilities which are certified as intermediate care facilities for individuals with intellectual disabilities, starting the first day of a facility's first statement of costs year which begins on or after July 1, 1985, or provide home- and community-based developmental disabilities traditional waiver services, starting the first day of a facility's first statement of costs year which begins on or after April 1, 2018; provided, however, that neither this section, nor the effective date, shall preclude the application and implementation of some or all of the provisions of this chapter through contract or through official statements of department policy. Specific sections of this chapter will be applied to services provided in distinct parts of state institutions for individuals with developmental disabilities which are certified as intermediate care facilities for individuals with intellectual disabilities. The sections of this chapter that apply are section 75-04-05-01; subsections 1, 4, and 5 of section 75-04-05-02; section 75-04-05-08; subsections 8 through 12 of section 75-04-05-09; sections 75-04-05-10, 75-04-05-11, and 75-04-05-12; subsections 1 through 10, 12 through 19, 21 through 29, 32, 34 through 37, 40, 42 through 45, 47 through 49, and 51 through 53 of section 75-04-05-13; sections 75-04-05-13.1, 75-04-05-15, 75-04-05-16, 75-04-05-17, 75-04-05-18, 75-04-05-19, 75-04-05-20, 75-04-05-21, 75-04-05-22, 75-04-05-23, and 75-04-05-24.

History: Effective July 1, 1984; amended effective July 1, 1984; June 1, 1985; June 1, 1995; August 1, 1997; July 1, 2001; May 1, 2006; July 1, 2012; January 1, 2013; April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01; 34 CFR 363

75-04-05-25. Indemnification.

Provider agencies may be required to indemnify and reimburse the department for any federal funds, the expenditure of which is disallowed as a consequence of the provider agency's failure to establish and maintain adequate records or the provider agency's failure to otherwise comply with written standards, rules and regulations, or statutes.

History: Effective April 1, 2018.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01