



**LYNGBLOMSTEN
CARE CENTER**
Financial

Revised 11/20/2025

(651) 632-5301
admissions@lyngblomsten.org
www.Lyngblomsten.org

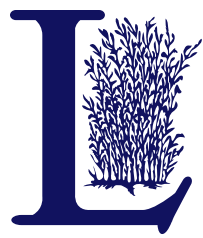




LYNGBLOMSTEN CARE CENTER

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LYNGBLOMSTEN CARE CENTER

Medical Assistance (MA) Guide

For a copy of the MA application form or for more information, please see the Business Office. You can also call Nick Davini at (651) 632-5314.

Why Medical Assistance (MA)?

Medical Assistance helps residents cover their healthcare costs at an affordable cost when they have either run out funds to pay privately or cannot afford the deductibles/co-pays left by their private healthcare plans.

Do you qualify?

The basic qualifications of MA take a look at a resident's overall assets. This includes things like income, burial accounts, resident trust accounts, cash value of life insurance policies, etc. The maximum value of assets is \$3,000. To qualify, a resident must be at or below this threshold at the time of application and throughout the application process. The application process will start when they get close to the threshold, and they will be approved once they spend down their assets.

When should you apply?

If you are currently at the \$3,000 threshold or below it, you should apply as soon as possible. MA can cover up to three months prior to the date of the application **if** requested and if the asset requirements are met. (For example, if you apply on August 25 and you were at or below \$3,000 going all the way back, MA can begin covering you as early as May 1. Be sure to request this "retro-coverage" in the application if you need it.)

For those who are currently paying privately for care, it is good to be aware of the application process and to begin gathering the needed information when funds are nearing \$3,000.

- When applying for MA, every type of asset listed on the application must be backed up by proof. For example, if you list that there is a checking account, a statement for that checking account must be attached. Keep in mind that some proofs are harder to obtain than others—having proofs and attaching them with the initial application is ideal and shortens the MA pending process.

Which form should you use?

There are three forms that we use regularly within our facility.

1. [DHS Form 3531](#)

Application for Medical Assistance for Long-Term Care Services

This form is for anyone who is new to MA and needs coverage.

2. [DHS Form 3543](#)

Request for Payment of Long-Term Care Services

This form is for those who currently have MA but have never used MA within a long-term care facility. This form converts “regular”/community MA to long-term care MA.

3. [DHS Form 2128](#)

Renewal for People Receiving Long-Term Care Services

This form is for anyone who has or who had MA and needs to renew. (Generally, the county will send out a notice stating that coverage is ending soon, and the resident must renew in order to keep coverage up to date.)

Once completed, these forms need to be sent to the corresponding county of residence for processing. A fax number is listed at the bottom of this guide for reference. You may also mail the form in. We suggest that you always make copies of everything that you send in and make a note about when it was sent in and how.

Are you married, and is your spouse living in the community?

If you are married and have a spouse living in the community, this changes MA. We suggest that you go ahead and apply, but understand that your spouse may qualify to receive a portion or all of your income in order to sustain them in the community. In some cases, this may lower or expel your MA “spenddown.”

If you have further general questions, you may contact our office. If you have detailed questions regarding the dividing of income and assets as a married couple within Minnesota and how MA may affect you, you should contact an elder law attorney. If you have already applied for MA, your assigned caseworker should be able to answer the questions that you have and inform you as to how this will affect your case and assets. If you have not yet been assigned a caseworker, please see the end of this guide for our current county caseworker contact information.

Once you apply, your case must go through the system (“intake”) and will be assigned to a caseworker. This generally takes about two weeks. Once assigned, the case will be “queued” in the caseworker’s case load, and depending on the pace that they work, it can take two or more weeks to review it and get back to you.

If the proofs needed have not been submitted or the caseworker needs more information, they will send out a letter requesting this; some workers will call you to verbally inform you of the information/proofs that they need. They will include a deadline for when that information must be submitted.

During the “MA Pending” phase, we ask all of our residents to pay the “estimated spenddown.” Using the following formula, you can compute your estimated spenddown per month:

For example: \$1,000 Social Security Income

- \$250 for Health Partners Premium
- \$104 for Personal Spending Allowance

**= \$646 Spenddown per month,
to be paid to Lynqblomsten Care Center**

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What happens if your case fails to get approved?

Your case may be denied for any number of reasons, but generally we only see this happen if:

- You fail to submit the requested documents in a timely manner
- You fail to spend down—if needed—the assets that are above the \$3,000 threshold

If your case is denied, then you have the ability to appeal the case decision. There must be a written notice to your caseworker within 10 days of receiving the denial notice. Once your caseworker receives this notice, they will begin the appeal process. This process may include court dates and require you to appear in person or over the phone to conduct an assessment of whether or not the denial was correctly issued.

Will Medical Assistance pay for my old bills?

The “retro-coverage” window is 3 months. This means that if you need Medical Assistance coverage for bills for prior months, Medical Assistance will only be able to cover up to 3 months from the date of application.

- If you apply on 10/1/20, you can get coverage for the current month of application and the 3 months prior. In this case, you could be covered for October, September, August, and July.
- If you are denied on 10/20/20, you can still reapply by 10/31/20 and be subject to the same approval period of July through October.
- Although this does not apply to everyone, individuals in a time-sensitive case will need to pay attention to these time constraints to ensure that they qualify for all the coverage needed.

Although your window might allow you to apply for coverage up to 3 months prior, you may not qualify if your assets exceed the \$3,000 allowed during one of those months. For example, if you still have \$5,000 in July and did not spend those funds down until August, you would only qualify from August until October going forward.

- In cases like these, the county may still approve you but assess an “adjusted spenddown.” This means that you’d pay the \$2,000 to get from \$5,000 to \$3,000 towards the month of July, and then Medical Assistance would cover the remaining balance towards the facility. After this initial “adjusted spenddown,” you’ll be assigned an actual spenddown based on income thereafter (August going forward).

What happens after your case gets approved?

If your case gets approved, your caseworker will send you information regarding the “effective date” of when coverage begins and the “spenddown” amount for each month following. This information should also be sent to our facility. In case it is not, please check in with us so that we are billing you the correct amount and have MA in our system as a payer.

- We will “re-run” our billing system to the date of approval and issue a new bill with MA as a payer. Once you are on MA, each month will be billed at the spenddown assigned by the county. They will allow you to keep \$104 for spending. (This may increase as the cost of living increases each year.)
- Your spenddown will be listed on the statement that we send out; this should be paid each month to our facility. We will bill MA for the remaining costs due.
- The spenddown works like a deductible. If your care privately costs \$10,000/month and your spenddown is \$1,000, we will bill you for the \$1,000 spenddown. The remaining \$9,000 will be billed to MA. *Keep in mind that these numbers are only being used as an example.*

NOTE: Your social security income and other forms of income DO NOT automatically start coming to the facility. Your income will continue to go to where it has been assigned. It will continue to need to be managed as before. If you would like Lyngblomsten to manage your funds, please ask a staff member from the Business Office about our “Representative Payee” process.

What happens to my old healthcare plan and/or supplemental plans?

You are allowed to keep any private healthcare plans. As shown above, the county allows you to pay towards these plans without penalty to you. If the plan is for you to stay here long term, your healthcare plans may not be used as they would if you were living in the community, but can be maintained in the event you do return to the community.

Many families/residents like to keep these plans in place as a safety net for the future.

Again, keeping these plans does not negatively affect you. If you get rid of your plan, the money that you do not pay towards your plan will then be adjusted so that you pay it towards the facility. Each resident is only allowed \$104 as a personal spenddown allowance each month. Paying for a private healthcare premium will not affect this.

Other things to keep in mind:

- The Medical Assistance application and process is the responsibility of the resident/resident's family to complete. Although we as a facility are able to aid in this process by answering questions and faxing over information/proofs, it is left to the resident/family to ensure that everything the county needs and has requested is fulfilled. **If the case is denied due to failure to satisfy the county's requests, any private pay balance resulting in the lack of MA coverage will be due from the resident or the individual holding responsibility for handling the resident's affairs if they are unable to do so on their own.**
- Not all caseworkers work at the same pace. Some are very efficient, and some may not be. If you are having trouble with your caseworker, you can contact the Business Office to see if we can aid in getting in touch with a caseworker.
- If you need an extension for gathering proofs, your caseworker may be able to extend the deadlines for you. This is something you need to discuss with them.
- The county may need you to "spend down" assets if you are over the \$3,000 limit. This needs to be accounted for in a very detailed manner.
 - The spenddown of assets may only be done for the resident. Money that is "gifted" away or spent on other people besides the resident may result in denial of the case or a penalty period.
 - Items like gift cards or gift certificates do not count as a spenddown of assets. The county treats this as a means of "hiding assets" for later use.
 - Monetary donations cannot be made. Donating to churches, funds, or events do not count as spenddown and may instead be counted as a penalty.
- The county may conduct a "look-back" of up to 5 years from the date of application. Any money gifted away or used on things other than for the resident may be assessed.
- Once approved, cases will be "renewed" every year at least once. Some cases may need to be reviewed more than this, but this is not the general case. During this renewal period, all current assets will need to be verified with proofs and the short "renewal form."

Important Contact Information and People:

Ramsey County Human Services

(651) 266-4444

If mailing, mail to:

Ramsey County Health & Wellness

ATTN: Medical Assistance Case Management / WORKER NAME

160 East Kellogg Blvd.

St. Paul, MN 55101-1494

Charlotte T.

(651) 266-4517

*Caseworker who frequently works
with our residents' cases*

Jenny Z.

(651) 395-1637

Intake worker who assigns cases

Medical Assistance NEW CASES Fax Number

(651) 266-3932

Only to be used for completely new cases in need of assignment.

If mailing, mail to the address above.

Medical Assistance Fax Number

(651) 266-3933

For proofs/additional info for current open or pending cases.

If mailing, mail to the address above.



LYNGBLOMSTEN CARE CENTER

Bed Hold and Return to the Facility Notice

This notice is provided at admission and prior to each hospital transfer or therapeutic leave thereafter. You will be asked at the time of hospital transfer or therapeutic leave if you would like to hold your bed. If no answer or decision is received, per the Resident Bill of Rights, Lyngblomsten Care Center will hold your bed by default and you will be charged during hospitalization or therapeutic leave. You will continue to be charged for the bed hold until you inform your nurse, social worker, or the Business Office that you wish to release your bed hold. You will be charged at the daily room rate established prior to the leave, beginning with the day you transfer to the hospital or depart for your therapeutic leave.

For Medicare A/HMO (Medicare Advantage Plan) Recipients, Private Pay/Hospice:

- During a bed hold, you or your representative assumes responsibility for paying for your room in order for the facility to hold it for you.
- Medicare/HMO (Medicare Advantage Plan) will not pay the daily room rate while you are in the hospital and does not allow you to take therapeutic leave days during coverage.
- You will be billed at a percentage of the daily case mix rate determined prior to hospitalization. This calculation is 30% of the daily room rate for semi-private rooms and 100% for private rooms. Please contact our Business Office if you would like help calculating this at (651) 646-2941.
- In accordance with the Minnesota Medical Assistance rules, the facility will hold your bed for up to eighteen (18) days for every separate and distinct episode of medically necessary hospitalization.
- You are obligated to inform your nurse, social worker, or the Business Office as soon as possible if you decide not to hold your bed.

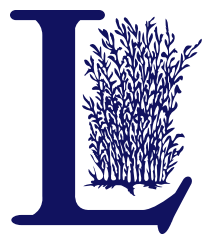
- If you choose to hold the bed beyond eighteen (18) days, you or your representative must contact the Business Office prior to the bed hold expiration and payment will continue.
- If you choose not to hold your bed, you or your representative have 24 hours to remove all personal items, clothing, furniture, and decorations from the room. We do understand that it may be a challenge to do this within 24 hours. If it is not possible for you to meet that time frame, please contact the neighborhood nurse on duty or social worker to give permission for your belongings to be packed by staff for you within the 24-hour period.
- If you decide to give up your bed or you exceed your 18-day bed hold period, you may return to the facility to your previous room if it is available or immediately upon the first availability of a bed in a semiprivate room if you:
 - Require the services provided by the facility; and
 - Are eligible for Medicare skilled nursing facility services or Medicaid nursing facility services; and
 - If your needs can be met by the facility.

For Medical Assistance Recipients:

- In accordance with Medical Assistance rules, Medical Assistance will pay to hold your bed for up to eighteen (18) days for every separate and distinct episode of medically necessary hospitalization and thirty-six (36) therapeutic leave days per calendar year.
- If you currently have a private room and receive Medical Assistance, the private room supplementation charge will continue during the bed hold period for hospitalization and therapeutic leave. This means you or your representative assume responsibility for continued payment of the private room supplement.
- You are obligated to inform the neighborhood social worker or the Business Office as soon as possible if you decide not to hold your bed.
- If you choose to hold the bed beyond eighteen (18) days, you or your

representative must contact the Business Office prior to the bed hold expiration and set-up private-pay payments.

- If you decide to give up your bed or you exceed your 18-day bed hold period, you may return to the facility to your previous room if it is available or immediately upon the first availability of a bed in a semiprivate room if you:
 - Require the services provided by the facility; and
 - Are eligible for Medicare skilled nursing facility services or Medicaid nursing facility services; and
 - If your needs can be met by the facility.
- If you choose not to hold your bed, you or your representative have 24 hours to remove all personal items, clothing, furniture, and decorations from the room. We do understand that it may be a challenge to do this within 24 hours. If it is not possible for you to meet that time frame, please contact the neighborhood nurse on duty or social worker to give permission for your belongings to be packed by staff for you within the 24-hour period.



LYNGBLOMSTEN CARE CENTER

Case Mix Questions and Answers

What is case mix?

Minnesota Case Mix is a system that classifies residents into distinct groups, called Resource Utilization Groups (RUGs), based on the resident's condition and the care the resident was receiving at the time of the assessment. These groups determine the daily rate the facility charges for the resident's care. A value is assigned to each classification, which is then used to calculate the daily rate of payment.

Q: How do I know how much I have to pay for nursing home care?

A: Each resident or the resident's representative receives a notice of the case mix classification. The actual cost of that classification is available from the facility.

Q: Do I have to do anything when I receive my case mix classification notice?

A: If you have no questions about your classification, you do not have to do anything. If you have questions about your classification, ask nursing home staff to explain it to you.

Q: What if I disagree with my classification?

A: You have the right to request a reconsideration of your case mix classification **within 30 calendar days** of receiving your case mix classification notification. If you request, nursing facility staff may assist you with this process. The Office of Ombudsman for Long-Term Care (number below) is an advocacy agency for persons receiving long-term care services and is separate from the Minnesota Department of Health and the nursing home. (See "Requesting a Reconsideration" fact sheet.)

Q: Do all nursing homes have the same rates?

A: No. While all nursing facilities in the Medicaid program use the same case mix system, the rates associated with each case mix category are unique to each facility. The rates are determined under statute, and take into account historic rates, costs of operation and legislated rate adjustments. Questions about rates may be directed to the Long-Term Care Policy Center at the Minnesota Department of Human Services at (651) 431-2282.

Q: How can I get more information about Minnesota Case Mix?

A: Contact staff at the nursing home, the Case Mix Review staff at the Minnesota Department of Health (see information at end of this document), or the Office of Ombudsman for Long-Term Care at (651) 431-2555 or toll free at 1-800-657-3591.

What assessments are used for Case Mix?

How often are assessments completed?

Nursing Facilities are required to complete assessments on residents at least every 92 days. A comprehensive assessment (Admission, Significant Change in Status, or Annual) is required at least every 366 days.

Which assessments are used by Minnesota Case Mix to generate RUG Classifications and when are they completed?

Note: Minnesota Case Mix does not use assessments completed solely for Medicare.

Admission Assessment: A comprehensive assessment completed

- when the resident first enters a nursing facility; OR
- when the resident reenters a nursing home after being gone 30 days or longer; OR
- when a resident returns to a nursing facility after being discharged return not anticipated.

Quarterly Assessment: Completed at least every 92 days following the previous assessment. It is used to track a resident's status between comprehensive assessments.

Annual Assessment: Completed at least every 92 days following the previous assessment and at least every 366 days following the most recent comprehensive assessment (Admission, Annual, or Significant Change in Status).

Significant Change in Status Assessment:

Completed when there is a decline or improvement in the resident's condition that:

1. will not normally resolve itself without intervention by staff and is not self limiting; AND
2. impacts more than one area of the resident's health status; AND
3. Requires interdisciplinary review and/or revision of the care plan.

Note: A Significant Change in Status Assessment must be completed when a resident enrolls or revokes hospice after the Admission Assessment is submitted.

RUG-IV **Case Mix Review** **Fact Sheets #1A and #3** *Updated August 2019*

Contact us:

Case Mix Review
PO Box 64938
St. Paul, MN 55164-0938
Phone: 651-201-4301
Fax: 651-215-9691

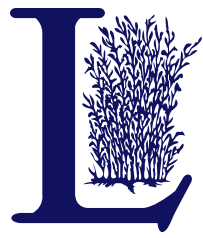
Website:

www.health.state.mn.us/facilities/regulation/casemix

Email:

Health.FPC-CMR@state.mn.us

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Daily Rates

as of 01/01/25

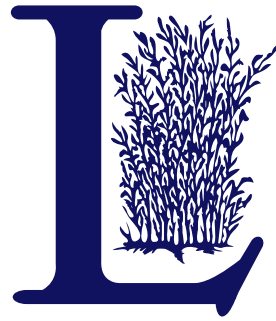
For information on calculation of
Daily Rates, see our Case Mix handout.

Case Mix Level	Day 1-30 @120%		Day 31+	
	Double Room	Private Room	Double Room	Private Room
ES3	\$1,018.81	\$1,206.42	\$901.66	\$1,005.35
ES2	\$877.44	\$978.35	\$731.20	\$815.29
ES1	\$874.78	\$975.37	\$728.98	\$812.81
RAE	\$723.36	\$806.54	\$602.80	\$672.12
RAD	\$704.76	\$785.81	\$587.30	\$654.84
RAC	\$646.32	\$720.65	\$538.60	\$600.54
RAB	\$577.25	\$643.63	\$481.04	\$536.36
RAA	\$502.86	\$560.69	\$419.05	\$467.24
HE2	\$784.45	\$874.67	\$653.71	\$728.89
HE1	\$675.54	\$753.23	\$562.95	\$627.69
HD2	\$733.98	\$818.39	\$611.65	\$681.99
HD1	\$638.35	\$711.77	\$531.96	\$593.14
HC2	\$702.11	\$782.86	\$585.09	\$652.38
HC1	\$611.78	\$682.14	\$509.82	\$568.45
HB2	\$696.79	\$776.93	\$580.66	\$647.44
HB1	\$609.12	\$679.16	\$507.60	\$565.97
LE2	\$712.73	\$794.69	\$593.94	\$662.24
LE1	\$619.75	\$691.02	\$516.46	\$575.85
LD2	\$694.14	\$773.96	\$578.45	\$644.97
LD1	\$606.47	\$676.21	\$505.39	\$563.51
LC2	\$630.37	\$702.86	\$525.31	\$585.72
LC1	\$556.00	\$619.93	\$463.33	\$516.61
LB2	\$606.47	\$676.21	\$505.39	\$563.51

Case Mix Level	Day 1-30 @120%		Day 31+	
	Double Room	Private Room	Double Room	Private Room
LB1	\$537.40	\$599.20	\$447.83	\$499.33
CE2	\$654.29	\$729.53	\$545.24	\$607.94
CE1	\$617.10	\$688.07	\$514.25	\$573.39
CD2	\$627.72	\$699.91	\$523.10	\$583.26
CD1	\$590.53	\$658.44	\$492.11	\$548.70
CC2	\$571.93	\$637.70	\$476.61	\$531.42
CC1	\$540.05	\$602.15	\$450.04	\$501.79
CB2	\$537.40	\$599.20	\$447.83	\$499.33
CB1	\$510.83	\$569.57	\$425.69	\$474.64
CA2	\$478.96	\$534.04	\$399.13	\$445.03
CA1	\$457.70	\$510.34	\$381.42	\$425.28
BB2	\$500.21	\$557.74	\$416.84	\$464.78
BB1	\$484.27	\$539.96	\$403.56	\$449.97
BA2	\$439.10	\$489.60	\$365.92	\$408.00
BA1	\$425.82	\$474.79	\$354.85	\$395.66
PE2	\$617.10	\$688.07	\$514.25	\$573.39
PE1	\$595.84	\$664.36	\$496.53	\$553.63
PD2	\$590.53	\$658.44	\$492.11	\$548.70
PD1	\$566.62	\$631.78	\$472.18	\$526.48
PC2	\$526.78	\$587.35	\$438.98	\$489.46
PC1	\$510.83	\$569.57	\$425.69	\$474.64
PB2	\$470.99	\$525.16	\$392.49	\$437.63
PB1	\$457.70	\$510.34	\$381.42	\$425.28
PA2	\$415.20	\$462.95	\$346.00	\$385.79
PA1	\$404.57	\$451.09	\$337.14	\$375.91
AAA	\$404.57	\$451.09	\$337.14	\$375.91
DDF	\$550.68	\$614.00	\$458.90	\$511.67
Private Room Differential		11.5%		11.5%

Note: Any rate determination made prior to admission is tentative and will be reassessed after admission.

Average Daily Rate: \$600/day





Influenced by Christ, Lyngblomsten provides a ministry of
compassionate care and innovative services to older adults in
order to preserve and enhance their quality of life.

www.Lyngblomsten.org