facility peer groups, the Department will collapse a peer group with fewer than seven nursing facilities into the adjacent peer group with the same bed size. If there are two adjacent peer groups with which to merge, the peer group with fewer than seven nursing facilities will be collapsed into the peer group with the larger population MSA group.

For rate years 2009-2010, 2010-2011 and 2011-2012, county nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv) (relating to peer grouping for price-setting).

For rate year 2012-2013 and thereafter, county nursing facilities' allowable MA costs will not be used in the rate-setting process for non-public nursing facilities.

3. Peer Group Price and Net Operating Rate Setting

Once the Department classifies nursing facilities into the appropriate peer groups, the Department then calculates the prices for each peer group. Under the case-mix payment system, nursing facility net operating costs are separated into three cost centers: resident care cost center, other resident related cost center and administrative cost center. The Department sets prices for each cost center and peer group on an

annual basis. After it sets the peer group prices, the Department uses the prices to calculate rates for the three net operating cost centers for each nursing facility.

a. Resident Care

To calculate the resident care cost medians and prices, the total resident care cost for each cost report is divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year. The Department divides the case-mix neutral audited allowable resident care costs for each cost report for each nursing facility by the nursing facility's total audited actual resident days for each cost report year to obtain each nursing facility's case-mix neutral resident care cost per diem for each cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

The Department arrays the average resident care cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.17 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price for each peer group will be the phase-out median as determined in accordance with paragraph d. below.

The Department calculates each nursing facility's resident care rate by determining the lower of the nursing facility's resident care peer group price or 103% of the nursing facility's case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility peer group price. The Department then adjusts the rate each quarter by multiplying the rate by the nursing facility's MA case-mix index (CMI) to set the facility specific rate for resident care.

b. Other Resident Related

To calculate the other resident related cost medians and prices, the Department divides the audited allowable other resident related costs for each cost report for each nursing facility by the nursing facility's total audited actual resident days for each cost report year to obtain each nursing facility's other resident related cost per diem for each cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

The Department arrays the average other resident related cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.12 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012, the median used to set the other resident related price for each peer group will be the phase-out median as determined in accordance with and paragraph d. below.

The Department calculates each nursing facility's facility-specific other resident related rate by taking the lower of the nursing facility's resident related peer group price or 103% of the nursing facility's resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility peer group price.

c. Administrative

The allowable administrative costs are determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs. To calculate the administrative cost medians and prices, the Department adjusts, as appropriate, the total audited actual resident days for each nursing facility to a minimum 90%

occupancy. The Department then divides the audited allowable administrative costs for each cost report for each nursing facility by the total audited actual resident days, adjusted to 90% occupancy, if applicable, for each cost report year to obtain each nursing facility's administrative cost per diem for the cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

The Department arrays the average administrative cost per diem for each nursing facility within the respective peer groups to determine a median for each peer group. The Department multiplies each median by a factor of 1.04 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012, the median used to set the administrative price for each peer group will be the phase-out median as determined in accordance with paragraph d. below.

A nursing facility's administrative rate equals its administrative peer group price.

d. Phase-Out Median Determination

(1) Beginning with rate year 2006-2007, and thereafter, county MA nursing facilities will not be reimbursed under the case-mix payment system. However, for rate years 2006-2007, 2007-2008 and 2008-2009, county MA nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with §1187.94 (1)(iv) (relating to peer group for price-setting) and the audited county nursing facilities' net operating costs allowable under Chapter 1187, from the three most recent audited cost reports will be included in the established peer groups when determining a median in accordance with §1187.96 (relating to price and rate setting computations).

(2) For rate years 2009-2010, 2010-2011 and 2011-2012, the Department will determine a phase-out median for each net operating cost center for each peer group to calculate a peer group price. The Department will establish the phase-out median as follows:

(a) The Department will establish an interim phase out median for the rate year as follows:

(i) County nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv) (relating to peer grouping for price setting).

(ii) The audited county nursing facilities' net operating costs allowable under Chapter 1187, from the three most recent audited cost reports will be included in the established peer groups when determining a median in accordance with § 1187.96 (relating to price and rate setting computations).

(b) The phase-out median for 2009-2010 rate year will equal 75% of the interim median calculated in accordance with (a) above plus 25% of the median calculated in accordance with § 1187.96.

(c) The phase-out median for 2010-2011 rate year will equal 50% of the interim median calculated in accordance with (a) above plus 50% of the median calculated in accordance with § 1187.96 .

(d) The phase-out median for 2011-2012 rate year will equal 25% of the interim median calculated in accordance with (a) above plus 75% of the median calculated in accordance with § 1187.96.

(3) For rate year 2012-2013 and thereafter, county nursing facilities' allowable MA costs will not be used in the rate-setting process for non-public nursing facilities.

e. Net Operating Rate

The Department determines each nursing facility's per diem net operating rate by adding the nursing facility's case-mix adjusted resident care rate, its other resident related rate and its administrative rate.

4. Capital Rate Setting

The facility-specific capital rate consists of three components: the fixed property component, the movable property component, and the real estate tax component.

(a) Fixed Property Component

The nursing facility's fixed property component is based on the nursing facility's allowable beds, as defined in § 1187.2 (relating to definitions), multiplied by an assigned cost of $26,000 and the associated financial yield rate.

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(b) Movable Property Component

The Department bases the amount of the movable property component on the audited actual acquisition costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database.

(c) Real Estate Tax Cost Component

The Department determines the real estate tax cost component of each nursing facility's capital rate based on the audited actual real estate tax cost, as set forth on the most recent audited MA-11 cost report available in the NIS database.

(d) Capital Rates

The Department adds the nursing facility's fixed property component, movable property component and real estate tax component and divides the sum of the three components by the nursing facility's total actual resident days, adjusted to 90% occupancy, if applicable.

(e) In accordance with § 1187.97, if a county nursing facility becomes a nursing facility between July 1, 2006 and June 30, 2012, the per diem rate for the nursing facility will be computed in accordance with § 1187.96, using the data contained in the NIS database.

C. Cost Finding

All nursing facilities participating in the Medical Assistance Program shall use the direct allocation method of cost finding. Under this method of cost finding, costs are apportioned directly to the nursing facility and residential or other facility based on the appropriate financial and statistical data.

D. Cost Reporting and Audit Requirements

All nursing facilities participating in the MA Program shall report allowable costs and the results of the cost finding process on forms specified by the Department. Allowable costs are classified in four cost centers: resident care; other resident related; administrative and capital. Net operating costs include resident care, other resident related and administrative. All records are subject to verification and audit. The financial and statistical records of all nursing facilities are audited periodically by the Department.

The Pennsylvania Department of Public Welfare recognizes reserved bed days as a allowable cost when an MA resident is absent from a nursing facility for a continuous 24-hour period for the purpose of hospitalization or for therapeutic leave.

A. Hospitalization

1. A resident receiving nursing facility services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will pay a nursing facility at a rate of one-third of the facility's current per diem rate on file with the Department for a hospital reserved bed day if the nursing facility meets the overall occupancy requirements as set forth below.

a. During the rate year 2009-2010, the nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurs shall equal or exceed 75%.

b. Beginning with rate year 2010-2011 and thereafter, the nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurs shall equal or exceed 85%.

c. The Department will calculate a nursing facility's overall occupancy rate for a rate quarter as follows:

(i) The Department will identify the picture date for the rate quarter (July 1 rate quarter – February 1 picture date; October 1 rate quarter – May 1 picture date; January 1 rate quarter – August 1 picture date; and April 1 rate quarter – November 1 picture date) and the two picture dates immediately preceding this picture date.

(ii) The Department will calculate the nursing facility's occupancy rate for each of the picture dates identified in (i) above, by dividing the total number of assessments listed in the facility's CMI report for that picture date by the number of the facility's certified beds on file with the Department on the picture date and multiplying the result by 100%. The Department will assign the highest of the three picture date occupancy rates as the nursing facility's overall occupancy rate for the rate quarter.

(iii) The Department will only use information contained on a valid CMI report to calculate a nursing facility's overall occupancy rate. If a nursing facility did not submit a valid CMI report for a picture date identified in (i) above, the Department will calculate the nursing facility's overall occupancy

rate based upon the valid CMI reports that are available for the identified picture dates. If no valid CMI reports are available for the picture dates identified in (i) above, the nursing facility is not eligible to receive payment for hospital reserve bed days in the rate quarter.

d. A new nursing facility is exempt from the applicable occupancy requirements set forth in 1.a. and 1.b. above, until a CMI Report for each of the three picture dates used to calculate overall occupancy as set forth in 1.c.(i) above is available for the rate quarter.

2. If the resident's hospital stay exceeds the Department's 15 reserved bed day payment limitation, the nursing facility shall readmit the resident to the nursing facility upon the first availability of a bed in the nursing facility if, at the time of readmission, the resident requires the services provided by the nursing facility.

3. If a bed is reserved for a hospitalized resident, it must be available to the resident upon the resident's return to the nursing facility. The bed need not remain empty pending the resident's return; however, it must be recorded as a resident day on the nursing facility's daily census and on the invoice if it is temporarily occupied by another resident. A bed reserved for a hospitalized resident is not counted as a resident if the bed remains empty.

B. Therapeutic Leave

A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the nursing facility providing the leave is included in the individual's plan of care and is ordered by the attending physician.

The Department will pay a nursing facility its current per diem rate on file with the Department for therapeutic leave days.

Each bed reserved for therapeutic leave must remain unoccupied pending the resident's return to the facility. The bed must be recorded as a resident day on the facility's daily census and on the invoice.