CHAPTER 1187. NURSING FACILITY SERVICES

Authority

The provisions of this Chapter 1187 issued under sections 201, 403 and 443.1 of the Public Welfare Code (62 P.S. §§ 201, 403 and 443.1), unless otherwise noted.

Source

The provisions of this Chapter 1187 adopted October 13, 1995, effective January 1, 1996, 25 Pa.B. 4477, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities); and 55 Pa. Code § 1189.51 (relating to allowable costs).

Subchapter A. GENERAL PROVISIONS

§ 1187.1. Policy.

(a) This chapter applies to nursing facilities, and to the extent specified in Chapter 1189 (relating to county nursing facility services), to county nursing facilities.

(b) This chapter governs MA payments to nursing facilities on the basis of the Commonwealth's approved State Plan for reimbursement.

(c) The MA Program provides payment for nursing facility services provided to eligible recipients by enrolled nursing facilities. Payment for services is made subject to this chapter and Chapter 1101 (relating to general provisions).

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of a cost report, resident assessment data, an appeal or an amended appeal cannot be extended, except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed for nursing facilities by this chapter with respect to the filing of a cost report, resident assessment data, an appeal or an amended appeal may be permitted only upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

Authority

The provisions of this § 1187.1 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.1 amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (313073) to (313074).

Cross References

This section cited in 55 Pa. Code § 41.33 (relating to appeals nunc pro tunc); 55 Pa. Code § 1187.73 (relating to annual reporting); 55 Pa. Code § 1187.75 (relating to final reporting); and 55 Pa. Code § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Accrual basis—An accounting method by which revenue is recorded in the period when it is earned, regardless of when it is collected, and expenses are recorded in the period when they are incurred, regardless of when they are paid.

Allowable bed—A nursing facility bed that is not subject to the limitation in § 1187.113 (relating to capital component payment limitation).

Allowable costs—Costs as identified in this chapter which are necessary and reasonable for an efficiently and economically operated nursing facility to provide services to MA residents.

Amortization—administrative costs—Costs not directly related to capital formation which are expended over a period greater than 1 year.

Amortization—capital costs—Preopening and ongoing costs directly related to capital formation and development which are expended over a period greater than 1 year. These costs include loan acquisition expenses as well as interest paid during the construction or preopening purchase period on a debt to acquire, build or carry real property.

Audited MA-11 cost reports—MA-11 cost reports that have been subjected to desk or field audit procedures by the Commonwealth and issued to providers.

Benefits, fringe—Nondiscriminatory employee benefits which are normally provided to nursing facility employees in conjunction with their employment status.

Benefits, nonstandard or *nonuniform*—Employe benefits provided to selected individuals, which are not provided to all nursing facility employes in conjunction with their employment status, or benefits which are not normally provided to employes.

CMI—Case-Mix Index—A number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident.

CMI Report—A report generated by the Department from submitted resident assessment records and tracking forms and verified by a nursing facility each calendar quarter that identifies the total facility and MA CMI average for the picture date, the residents of the nursing facility on the picture date and the following for each identified resident:

(i) The resident's payor status.

(ii) The resident's RUG category and CMI.

(iii) The resident assessment used to determine the resident's RUG category and CMI and the date and type of the assessment.

Classifiable data element—A data element on the Federally Approved Pennsylvania Specific Minimum Data Set (PA specific MDS) which is used for the classification of a resident into one of the RUG-III categories.

Cost centers—The four general categories of costs:

(i) Resident care costs.

(ii) Other resident related costs.

(iii) Administrative costs.

(iv) Capital costs.

County nursing facility—

(i) A long-term care nursing facility that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA program as a provider of nursing facility services.

(C) Controlled by the county institution district or by county government if no county institution district exists.

(ii) For the purposes of this defintion, ''controlled'' in clause (C) means the power to direct or cause to direct the management and policies of the nursing facility, whether through equitable ownership of voting securities or otherwise.

(iii) The term does not include intermediate care facilities for persons with an intellectual disability controlled or totally funded by a county institution district or county government.

DME—Durable medical equipment—

(i) Movable property that:

(A) Can withstand repeated use.

(B) Is primarily and customarily used to serve a medical purpose.

(C) Generally is not useful to an individual in the absence of illness or injury.

(ii) Any item of DME is an item of movable property. There are two classes of DME:

(A) *Exceptional DME.* DME that has a minimum acquisition cost that is equal to or greater than an amount specified by the Department by notice in the *Pennsylvania Bulletin* and is either specially adapted DME or other DME that is designated as exceptional DME by the Department by notice in the *Pennsylvania Bulletin*.

(B) *Standard DME.* Any DME, other than exceptional DME, that is used to furnish care and services to a nursing facility's residents.

Department—The Department of Human Services, which is the Commonwealth agency designated as the single State agency responsible for the administration of the Commonwealth's MA Program.

Department of Aging—The Commonwealth agency that, under a memorandum of understanding with the Department, conducts prescreening of target applicants applying for nursing facility services and the screening of MA nursing facility applicants to determine the need for services.

Department of Health—The Commonwealth agency that, under a memorandum of understanding with the Department, conducts certification surveys of nursing facilities in the MA Program.

Depreciated replacement cost—

(i) As used in conjunction with fixed property, depreciated replacement cost is the amount required to replace the fixed property with new and modern fixed property using the most current technology, code requirements/standards and construction materials that will duplicate the production capacity and utility of the existing fixed property at current market prices for labor and materials, less an allowance for accrued depreciation.

(ii) As used in conjunction with movable property, depreciated replacement cost is the amount required to replace the movable property with new and modern movable property, less an allowance for accrued depreciation.

Depreciation—A loss of utility and a reduction in value caused by obsolescence or physical deterioration such as wear and tear, decay, dry rot, cracks, encrustation or structural defects of property, plant and equipment.

Facility MA CMI—The arithmetic mean CMI for MA residents in the nursing facility for whom the Department paid an MA day of care on the picture date.

Federally Approved Pennsylvania (PA) Specific Minimum Data Set (MDS)—A minimum core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

Financial yield rate—The composite Aaa Corporate Bond Yield Average as reported in Moody's Bond Record for the 60-month period ending in March of each year.

Fixed property—Land, land improvements, buildings including detached buildings and their structural components, building improvements, and fixed equipment located at the site of the licensed nursing facility that is used by the nursing facility in the course of providing nursing facility services to residents. Included within this term are heating, ventilating, and air-conditioning systems and any equipment that is either affixed to a building or structural component or connected to a utility by direct hook-up.

Hospital-based nursing facility—A nursing facility that was receiving a hospital-based rate as of June 30, 1995, and is:

(i) Located physically within or on the immediate grounds of a hospital.

(ii) Operated or controlled by the hospital.

(iii) Licensed or approved by the Department of Health and meets the requirements of 28 Pa. Code § 101.31 (relating to hospital requirements) and shares support services and administrative costs of the hospital.

Independent assessor—An agent of the Department who performs comprehensive evaluations and makes recommendations to the Department regarding the need for nursing facility services or the need for specialized services, or both, for individuals seeking admission to or residing in nursing facilities.

Initial Federally-approved PA Specific MDS—The first assessment or tracking form completed for a resident upon admission.

Interest—

(i) *Capital interest.* The direct actual cost incurred for funds borrowed to obtain fixed property, major movable property or minor movable property.

(ii) *Other interest.* The direct actual cost incurred for funds borrowed on a short-term basis to finance the day-to-day operational activities of the nursing facility, including the acquisition of supplies.

Intergovernmental Transfer Agreement—The formal document that executes the transfer of funds or certification of funds to the Commonwealth by another unit of government within this Commonwealth in accordance with section 1903 of the Social Security Act (42 U.S.C.A. § 1396b(w)(6)(A)).

Investment income—Actual or imputed income available to or accrued by a nursing facility from funds which are invested, loaned or which are held by others for the benefit of the nursing facility.

LTCCAP—Long-Term Care Capitated Assistance Program—The Department's community-based managed care program for the frail elderly based on the Federal Program of All-inclusive Care for the Elderly (PACE) (see section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee)).

MA MCO—Medical Assistance Managed Care Organization—An entity under contract with the Department that manages the purchase and provision of health services, including nursing facility services, for MA recipients who are enrolled as members in the entity's health service plan.

MA conversion resident—A nursing facility resident who applies for and meets the eligibility requirements for MA payment for nursing facility services.

MA day of care—A day of care for which one of the following applies:

(i) The Department pays 100% of the MA rate for an MA resident.

(ii) The Department and the resident pay 100% of the MA rate for an MA resident.

(iii) An MA MCO or an LTCCAP provider that provides managed care to MA residents, pays 100% of the negotiated rate or fee for an MA resident's care.

(iv) The resident and either an MA MCO or LTCCAP provider that provides managed care to an MA resident, pays 100% of the negotiated rate or fee for an MA resident's care.

(v) The Department pays for care provided to an MA resident receiving hospice services in a nursing facility.

MA-11—Financial and Statistical Report Schedules (uniform nursing facility cost report)—A package of certifications, schedules and instructions which makes up the comprehensive cost report.

MSA group—Metropolitan Statistical Area—A statistical standard classification designated and defined by the Federal Office of Management and Budget following a set of official published standards.

Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services (CMS) Pub. 15-1)—Guidelines and procedures for Medicare reimbursement.

Movable property—A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and that is not fixed property or a supply. There are two classes of movable property:

(i) *Major movable property*. Any movable property that has an acquisition cost of $500 or more.

(ii) *Minor movable property*. Any movable property that has an acquisition cost of less than $500.

NIS—Nursing Information System—The comprehensive automated database of nursing facility, resident and fiscal information needed to operate the Pennsylvania Case-Mix Payment System.

Net operating costs—The following cost centers:

(i) Resident care costs.

(ii) Other resident related costs.

(iii) Administrative costs.

New nursing facility—A newly constructed, licensed and certified nursing facility; or an existing nursing facility that has never participated in the MA Program or an existing nursing facility that has not participated in the MA Program during the past 2 years.

Nursing facility—

(i) A long-term care nursing facility, that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by an individual, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include intermediate care facilities for persons with an intellectual disability, Federal or State-owned long-term care nursing facilities, Veteran's homes or county nursing facilities.

Peer groups—Groupings of nursing facilities for payment purposes under the case-mix system.

Pennsylvania Case-Mix Payment System—The nursing facility payment system which combines the concepts of resident assessments and prospective payment.

Per diem rate—A comprehensive rate of payment to a nursing facility for covered services for a resident day.

Picture date—The first calendar day of the second month of each calendar quarter.

Preadmission screening and resident review—The preadmission screening process that identifies target residents regardless of their payment source; and the resident review process that reviews target residents to determine the continued need for nursing facility services and the need for specialized services.

Price—A derivative of the allowable costs of the net operating cost centers which has been adjusted by 117% for resident care costs; 112% for other resident related costs; and 104% for administrative costs.

Private pay rate—The nursing facility's usual and customary charges made to the general public for a semiprivate room inclusive of ancillary charges.

Private pay resident—An individual for whom payment for services is made with the individual's resources, private insurance or funds from liable third parties other than the MA Program.

RNAC—Registered Nurse Assessment Coordinator—An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, and who is responsible for coordinating and certifying completion of the resident assessment.

RUG-III—Resource Utilization Group, Version III—A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.

Real estate tax cost—The cost of real estate taxes assessed against a nursing facility for a 12-month period, except that, if the nursing facility is contractually or otherwise required to make a payment in lieu of real estate taxes, that nursing facility's ''cost of real estate taxes'' is deemed to be the amount it is required to pay for a 12-month period.

Rebasing—The process of updating cost data for subsequent rate years.

Related party—A person or entity that is associated or affiliated with or has control of or is controlled by the nursing facility or has an ownership or equity interest in the nursing facility. The term ''control,'' as used in this definition, means the direct or indirect power to influence or direct the actions or policies of an organization, institution or person.

Related services and items—Services and items necessary for the effective use of exceptional DME. The term is limited to:

(i) Delivery, set up and pick up of the equipment.

(ii) Service, maintenance and repairs of the equipment to the extent covered by an agreement to rent the equipment.

(iii) Extended warranties.

(iv) Accessories and supplies necessary for the effective use of the equipment.

(v) Periodic assessments and evaluations of the resident.

(vi) Training of appropriate nursing facility staff and the resident in the use of the equipment.

Reorganized nursing facility—An MA participating nursing facility that changes ownership as a result of the reorganization of related parties or a transfer of ownership between related parties.

Resident assessment—A standardized evaluation of each resident's physical, mental, psychosocial and functional status.

Resident Data Reporting Manual—The Department's Manual of instructions for submission of resident assessment records and tracking forms and verification of the CMI report.

Resident day—The period of service for one resident for a continuous 24 hours of service. The day of the resident's admission is counted as a resident day. The day of discharge is not counted as a resident day.

Resident personal funds—Funds entrusted to a nursing facility by a resident which are in the possession and control of a nursing facility and are held, safeguarded, managed and accounted for by the facility in a fiduciary capacity for the resident.

Specially adapted DME—DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one resident, making its contemporaneous use by another resident unsuitable.

Special rehabilitation facility—A nursing facility with residents more than 70% of whom have a neurological/neuromuscular diagnosis and severe functional limitations.

Supply—

(i) A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and is normally consumed either in a single use or within a single 12-month period.

(ii) Examples of supplies include:

(A) Resident care personal hygiene items such as soap, toothpaste, toothbrushes and shampoo.

(B) Resident activity supplies such as game and craft items.

(C) Medical supplies such as surgical and wound dressings, disposable tubing and syringes, and supplies for incontinence care such as catheters and disposable diapers.

(D) Dietary supplies such as disposable tableware and implements and foodstuffs.

(E) Laundry supplies such as soaps and bleaches

(F) Housekeeping and maintenance supplies such as cleaners, toilet paper, paper towels and light bulbs.

(G) Administrative supplies such as forms, paper, pens and pencils, copier and computer supplies.

Target applicant or *resident*—An individual with a serious mental illness, intellectual disability or other related condition seeking admission to or residing in a nursing facility.

Total facility CMI—The arithmetic mean CMI of all residents regardless of the residents' sources of funding.

UMR—Utilization Management Review—An audit conducted by the Department's medical and other professional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents.

Year one of implementation—The period of January 1, 1996, through June 30, 1996.

Year two of implementation—The period of July 1, 1996, through June 30, 1997.

Year three of implementation and thereafter—The period of July 1, 1997, through June 30, 1998, and each subsequent Commonwealth fiscal year.

Authority

The provisions of this § 1187.2 amended under sections 201(2), 206(2), 403(b), 443.1(5) and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b), 443.1(5) and 454).

Source

The provisions of this § 1187.2 amended February 9, 2002, effective retroactively to November 1, 1999, for the definitions of ''DME—durable medical equipment,'' ''related services and items'' ''specially adapted DME.'' The remainder of amendment takes effect July 1, 2002, 32 Pa.B. 734; corrected April 19, 2002, effective February 9, 2002, 32 Pa.B. 1962; amended the definition of ''MA day of care'' effective January 1, 2004, and applies to DSH payments for fiscal periods ending on and after December 31, 2003, and to the MA CMI for picture dates beginning February 1, 2004, 35 Pa.B. 5120; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782; amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630; amended July 18, 2014, effective July 19, 2014, 44 Pa.B. 4498. Immediately preceding text appears at serial pages (361678), (354189) to (354190) and (358339) to (358344).

Cross References

This section cited in 55 Pa. Code § 41.92 (relating to expedited disposition for certain appeals); 55 Pa. Code § 1187.2a (relating to clarification of the term ''written''—statement of policy); 55 Pa. Code § 1187.91 (relating to database); 55 Pa. Code § 1187.152 (relating to additional reimbursement of nursing facility services related to exceptional DME); 55 Pa. Code § 1187.155 (relating to exceptional DME grants—payment conditions and limitations); 55 Pa. Code § 1187.158 (relating to appeals); and 55 Pa. Code § 1189.2 (relating to definitions).

§ 1187.2a. Clarification of the term "written"—statement of policy.

(a) The term ''written'' in the definition of ''specially adapted DME'' in § 1187.2 (relating to definitions) includes orders that are handwritten or transmitted by electronic means.

(b) Written orders transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

Source

The provisions of this § 1187.2a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

Subchapter B. SCOPE OF BENEFITS

Sec.
1187.11. Scope of benefits for the categorically needy.
1187.12. Scope of benefits for the medically needy.
1187.13. Scope of benefits for State Blind Pension recipients.
1187.14. Scope of benefits for qualified Medicare beneficiaries.

Cross References

This subchapter cited in 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities).

§ 1187.11. Scope of benefits for the categorically needy.

Categorically needy recipients as defined in § 1101.21 (relating to definitions) are eligible for nursing facility services subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

§ 1187.12. Scope of benefits for the medically needy.

Medically needy recipients as defined in § 1101.21 (relating to definitions) are eligible for nursing facility services subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

§ 1187.13. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for nursing facility services under the MA Program. Individuals who are blind or visually impaired are eligible for nursing facility services if they qualify as categorically or medically needy recipients.

§ 1187.14. Scope of benefits for qualified Medicare beneficiaries.

Qualified Medicare beneficiaries are eligible for nursing facility services only if they qualify as categorically or medically needy recipients.

Subchapter C. NURSING FACILITY PARTICIPATION

Sec.
1187.21. Nursing facility participation requirements.
1187.21a. [Reserved].
1187.22. Ongoing responsibilities of nursing facilities.
1187.23. Nursing facility incentives and adjustments.

Cross References

This subchapter cited in 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities).

§ 1187.21. Nursing facility participation requirements.

In addition to meeting the participation requirements established in Chapter 1101 (relating to general provisions), a nursing facility shall meet the following requirements:

(1) The nursing facility shall be licensed by the Department of Health.

(2) Every bed licensed by the Department of Health in a nursing facility that participates in the MA Program shall be certified for MA participation.

(3) The nursing facility shall abide by applicable Federal, State and local statutes and regulations, including Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396q), sections 443.1—443.6 of the Public Welfare Code (62 P. S. §§ 443.1—443.6) and applicable licensing statutes.

(4) An MA-enrolled nursing facility with 60 or more licensed beds providing skilled nursing and rehabilitation services in accordance with the Medicare requirements shall also be enrolled in the Medicare Program to the extent that it has sufficient beds to accommodate the Medicare-eligible residents it is required to serve. This does not preclude a nursing facility with a bed complement of under 60 beds from enrolling in the Medicare Program.

(i) A nursing facility certified to participate in the Medicare Program shall have sufficient beds to accommodate its Medicare-eligible residents. Payment will be based on criteria found in § 1187.101(b) (relating to general payment policy).

(ii) Failure to be enrolled and certified in the Medicare Program will result in denial of claims for a resident with both Medicare and MA coverage.

(5) The nursing facility shall meet the requirements of Subchapter L (relating to nursing facility participation requirements and review process).

Source

The provisions of this § 1187.21 amended June 29, 2012, effective June 30, 2012, 42 Pa.B. 3733. Immediately preceding text appears at serial page (354198).

§ 1187.21a. [Reserved].

Authority

The provisions of this § 1187.21a amended and reserved under section 443.1(8) of the Public Welfare Code (62 P. S. § 443.1(8)).

Source

The provisions of this § 1187.21a adopted January 9, 1998, effective January 12, 1998, 28 Pa.B. 138; amended April 2, 2010, effective April 3, 2010, 40 Pa.B. 1766; reserved June 29, 2012, effective June 30, 2012, 42 Pa.B. 3748. Immediately preceding text appears at serial pages (354198) and (348915) to (348922).

§ 1187.22. Ongoing responsibilities of nursing facilities.

In addition to meeting the ongoing responsibilities established in Chapter 1101 (relating to general provisions), a nursing facility shall, as a condition of participation:

(1) Assure that every individual applying for admission to the facility is prescreened by the Department as required by section 1919 of the Social Security Act (42 U.S.C.A. § 1396r(e)(7)) and 42 CFR Part 483, Subpart C (relating to preadmission screening and annual review of mentally ill and mentally retarded individuals).

(2) Assure that every individual who receives MA, who is eligible for MA or who is applying for MA, is reviewed and assessed by the Department or an independent assessor and found to need nursing facility services prior to admission to the nursing facility, or in the case of a resident, before authorization for MA payment.

(3) Assure immediate access to a resident by the following individuals:

(i) The resident's physician.

(ii) A representative of the Secretary of the United States Department of Health and Human Services.

(iii) A representative of the Commonwealth who is involved in the administration of the MA Program.

(iv) An ombudsman authorized by the Department of Aging, including those employed by a local area agency on aging.

(v) A representative of Pennsylvania Protection and Advocacy, the agency designated under Subchapter III of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 6041—6043) and the Protection and Advisory for Mentally Ill Individuals Act of 1986 (42 U.S.C.A. §§ 10801—10851).

(4) Assure that it is necessary for each resident to remain in the nursing facility.

(5) Assure that the data in each resident's Federally-approved PA Specific MDS are accurate and that all assessment records and tracking forms for the resident are completed and submitted to the Department as required by applicable Federal and State regulations and instructions, including the *Centers for Medicare and Medicaid Services Long-Term Care Resident Assessment Instrument User's Manual* and the *Resident Data Reporting Manual*.

(6) Assure and verify that the information contained on the quarterly CMI report is accurate for the picture date as specified in § 1187.33(a)(5) (relating to resident data and picture date reporting requirements) and the *Resident Data Reporting Manual*.

(7) Assure that each invoice for nursing facility services provided to each MA resident is accurate.

(8) Have in operation a system for managing residents' funds that, at a minimum, fully complies with the requirements established by Federal law and

[Next page is 1187-21.]

Federal and State regulations in accordance with § 1187.78 (relating to accountability requirements related to resident personal fund management).

(9) Cooperate with reviews and audits conducted by the Department and furnish the residents' clinical and fiscal records to the Department upon request.

(10) Provide written responses to the Department for UMR reports requiring corrective action.

(11) Take corrective action within acceptable time frames as described in UMR reports.

(12) File an acceptable cost report with the Department within the time limit specified in § 1187.73 or § 1187.75 (relating to annual reporting; and final reporting).

(13) In addition to meeting the reporting requirements of § 1101.43 (relating to enrollment and ownership reporting requirements), notify the Department in writing within 30 days of a change in the name or address of corporate officers.

(14) Submit a written request for MA nursing facility participation to the Department if the nursing facility changes ownership and the new owner wishes the nursing facility to participate in the MA Program. The agreement in effect at the time of the ownership change will be assigned to the new owner subject to applicable statutes and regulations and the terms and conditions under which it was originally issued.

(15) Assure that individual resident information collected in accordance with this chapter is kept confidential and released only for purposes directly connected to the administration of the MA Program.

(16) Maintain a separate written record in accordance with instructions by the Department, identifying the requests or physician's orders received by the facility for exceptional DME or other DME as specified by the Department.

(17) Notify the Department in writing within 15 days if an MA eligible resident refuses DME that the Department has determined is medically necessary.

(18) Submit the initial Federally-approved PA Specific MDS record for each resident admitted to the nursing facility to the Department within 7 calendar days of the date the record is completed.

Authority

The provisions of this § 1187.22 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.22 amended February 8, 2002, effective October 1, 2001, 32 Pa.B. 734; amended June 23, 2006, effective July 1, 2006, with the exception of § 1187.22(18) effective October 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (287007) to (287008).

Cross References

This section cited in 55 Pa. Code § 1187.158 (relating to appeals).

§ 1187.23. Nursing facility incentives and adjustments.

(a) The Department will make minimum occupancy adjustments to encourage nursing facility efficiency and economy associated with nursing facility occupancy levels. If the nursing facility's overall nursing facility occupancy level is below 90%, the Department will make an adjustment to total nursing facility resident days as though the nursing facility were at 90% occupancy. The Department will apply this 90% occupancy adjustment to the administrative cost component and the capital cost center.

(b) The Department will pay a disproportionate share incentive to a nursing facility that has a high overall occupancy and a high proportion of MA residents in accordance with § 1187.111 (relating to disproportionate share incentive payments).

Cross References

This section cited in 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations).

Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

Sec.

Cross References

This section cited in 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities).

§ 1187.31. Admission or MA conversion requirements.

A nursing facility shall meet the following admission or MA conversion requirements:

(1) *Prescreening*. The nursing facility shall ensure that individuals applying for admission to the facility are prescreened by the Department as required by section 1919 of the Social Security Act (42 U.S.C.A. § 1396r(e)(7)) and 42 CFR Part 483 Subpart C (relating to preadmission screening and annual review of mentally ill and mentally retarded individuals).

(2) *Preadmission or MA conversion evaluation and determination*.

(i) The nursing facility shall ensure that before an MA applicant or recipient is admitted to a nursing facility, or before authorization for MA payment for nursing facility services in the case of a resident, the MA applicant, recipient or resident has been evaluated by the Department or an independent assessor and found to need nursing facility services.

(ii) The nursing facility shall maintain a copy of the Department's or the independent assessor's notification of eligibility in the business office.

(3) *Notification to the Department*.

(i) The nursing facility shall notify the Department on forms designated by the Department whenever an MA applicant or recipient is admitted to the nursing facility or whenever a resident is determined eligible for MA.

(ii) The nursing facility shall submit information regarding target residents to the Department on forms designated by the Department within 48 hours of the admission of a target resident to the nursing facility.

(4) *Physician certification*. Within 48 hours of admission of a resident to a nursing facility or, if a resident applies for MA while in the nursing facility before the Department authorizes payment for nursing facility services, the nursing facility shall ensure that a resident's attending physician certifies in writing in the resident's clinical record that the resident requires nursing facility services.

Authority

The provisions of this § 1187.31 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.31 amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (287009) to (287010).

§ 1187.32. Continued need for nursing facility services requirements.

A nursing facility shall meet the following continued need for nursing facility services requirements:

(1) The nursing facility shall complete a new prescreening form for a resident whenever there is a change in the resident's condition that affects whether the resident is a target resident. The nursing facility shall maintain a copy of the new prescreening form in the resident's clinical record and notify the Department within 48 hours of the change in the resident's condition on forms designated by the Department.

(2) The nursing facility shall ensure that a resident's attending physician, or a physician assistant or nurse practitioner acting within the scope of practice as defined by State law and under the supervision of the resident's attending physician, recertifies the resident's need for nursing facility services in the resident's clinical record at the time the attending physician's orders are reviewed and renewed, consistent with Department of Health licensure time frames for renewing orders.

(3) The nursing facility shall notify the Department within 48 hours whenever the facility or resident's attending physician determines that the resident no longer requires nursing facility services. The notification shall be submitted on forms designated by the Department.

(4) The nursing facility shall obtain a physician's certification and written order for the resident's discharge whenever a resident no longer requires nursing facility services.

Authority

The provisions of this § 1187.32 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.32 amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial page (287010).

Cross References

This section cited in 55 Pa. Code § 1187.32a (relating to clarification of the term ''written''—statement of policy).

§ 1187.32a. Clarification of the term "written"—statement of policy.

(a) The term ''written'' in § 1187.32(4) (relating to continued need for nursing facility services requirements) includes orders that are handwritten or transmitted by electronic means.

(b) Written orders transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

Source

The provisions of this § 1187.32a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

§ 1187.33. Resident data and picture date reporting requirements.

(a) *Resident data and picture date requirements*. A nursing facility shall meet the following resident data and picture date reporting requirements:

(1) The nursing facility shall submit the resident assessment data necessary for the CMI report to the Department as specified in the *Resident Data Reporting Manual*.

(2) The nursing facility shall ensure that the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical records maintained by the nursing facility.

(i) The nursing facility's clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

(ii) The Federally approved PA specific MDS shall be coordinated and certified by the nursing facility's RNAC.

(iii) The records listed in this section are subject to periodic verification and audit.

(3) The nursing facility shall maintain the records pertaining to each Federally-approved PA Specific MDS record and tracking form submitted to the Department for at least 4 years from the date of submission.

(4) The nursing facility shall ensure that resident assessments accurately reflect the residents' conditions on the assessment date.

(5) The nursing facility shall correct and verify that the information in the quarterly CMI report is accurate for the picture date and in accordance with paragraph (6) and shall sign and submit the CMI report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter.

(6) The CMI report must include resident assessment data for every MA and every non-MA resident included in the census of the nursing facility on the picture date.

(i) A resident shall be included in the census of the nursing facility on the picture date if all of the following apply:

(A) The resident was admitted to the nursing facility prior to or on the picture date.

(B) The resident was not discharged with return not anticipated prior to or on the picture date.

(C) Any resident assessment is available for the resident from which data may be obtained to calculate the resident's CMI.

(ii) A resident who, on the picture date, is temporarily discharged from the nursing facility with a return anticipated shall be included in the census of the nursing facility on the picture date as a non-MA resident.

(iii) A resident who, on the picture date, is on therapeutic leave shall be included in the census of the nursing facility on the picture date as an MA resident if the conditions of § 1187.104(2) (relating to limitations on payment for reserved beds) are met on the picture date. If the conditions of § 1187.104(2) are not met, the resident shall be included in the census of the nursing facility as a non-MA resident.

(b) *Failure to comply with the submission of resident assessment data.*

(1) If a valid assessment is not received within the acceptable time frame for an individual resident, the resident will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

(2) If an error on a classifiable data element on a resident assessment is not corrected by the nursing facility within the specified time frame, the assumed answer for purposes of CMI computations will be ''no/not present.''

(3) If a valid CMI report is not received in the time frame outlined in subsection (a)(5), the facility will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

Authority

The provisions of this § 1187.33 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.33 amended June 23, 2006, effective July 1, 2006, with the exception of § 1187.33(a) effective October 1, 2006, 36 Pa.B. 3207; amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630. Immediately preceding text appears at serial pages (351452) and (354199).

Cross References

This section cited in 55 Pa. Code § 1187.22 (relating to ongoing responsibilities of nursing facilities); 55 Pa. Code § 1187.32 (relating to continued need for nursing facility services requirements); 55 Pa. Code § 1187.91 (relating to database); 55 Pa. Code § 1187.92 (relating to resident classification system); 55 Pa. Code § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities); 55 Pa. Code § 1187.104 (relating to limitations on payment for reserved beds); 55 Pa. Code § 1187.117 (relating to supplemental ventilator care and tracheostomy care payments); 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities); and 55 Pa. Code § 1189.105 (relating to incentive payments).

§ 1187.34. Requirements related to notices and payments pending resident appeals.

(a) The requirements relating to notices authorizing and discontinuing MA payments for nursing facility services are as follows:

(1) *Notices authorizing MA payment.*

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice authorizing MA nursing facility services for each MA conversion resident and for each MA applicant or recipient who is admitted as a resident.

(ii) The Department's notice authorizing MA nursing facility services will specify the effective date of coverage and the amount of money that the resident has available to contribute towards payment. The nursing facility is responsible to obtain the resident's share of the payment.

(2) *Notices discontinuing MA payment.*

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice discontinuing payment for MA nursing facility services for every resident who the Department determines is no longer eligible to receive MA nursing facility services. The Department's determination may be based upon a review conducted by the Department or the resident's attending physician.

(ii) The Department's notice discontinuing payment for MA nursing facility services will specify the effective date of the discontinuance of coverage, that the resident may appeal the notice within 30 days and that the resident must appeal within 10-calendar days of the date the notice was mailed in order for payments to continue pending the outcome of the hearing on the resident's appeal.

(b) The requirements relating to payments pending resident appeals and recovery of payments subsequent to appeals are as follows:

(1) *Payments pending appeal.*

(i) If the resident or a representative of the resident appeals the Department's notice discontinuing payment for MA nursing facility services within 10-calendar days of the date on which the notice was mailed to the resident, the Department will continue payments to the nursing facility for nursing facility services rendered to the resident pending the outcome of the hearing on the resident's appeal subject to paragraph (2).

(ii) If the resident or a representative of the resident does not appeal the Department's notice discontinuing payment for MA nursing facility services, or appeals after 10-calendar days from the date on which the notice was mailed to the resident, the Department will cease payment to the nursing facility for services rendered to the resident beginning on the effective date of the discontinuance of coverage specified in the notice or the date on which the resident was discharged from the facility, whichever date occurs first.

(2) *Payment recovery for services rendered pending appeal.* If a resident's appeal of a notice of discontinuance of payment for MA nursing facility services is denied, the Department will recover payments made to the nursing facility. The period for which the Department will recover payments will begin on the effective date of the discontinuance of coverage specified in the notice

to the resident and end on the date on which payments were discontinued as a result of the outcome of the hearing on the resident's appeal or the date of the resident's discharge from the facility, whichever date occurs first.

Subchapter E. ALLOWABLE PROGRAM COSTS AND POLICIES

Sec.

§ 1187.51. Scope.

(a) This subchapter sets forth principles for determining the allowable costs of nursing facilities.

(b) *The Medicare Provider Reimbursement Manual* (CMS Pub. 15-1) and the Federal regulations in 42 CFR Part 489 (relating to provider and supplier agreements) appropriate to the reimbursement for nursing facility services under the Medicare Program are a supplement to this chapter. If a cost is included in this subchapter as allowable, the CMS Pub. 15-1 and applicable Federal regulations may be used as a source for more detailed information on that cost. The CMS Pub. 15-1 and applicable Federal regulations will not be used for a cost that is nonallowable either by a statement to that effect in this chapter or because the cost is not addressed in this chapter or in the MA-11. The CMS Pub. 15-1 or applicable Federal regulations will not be used to alter the treatment of a cost provided for in this subchapter or the MA-11.

(c) The Department's payment rate for nursing facility services to eligible residents in participating nursing facilities includes allowable costs for routine services. Routine services may include the following:

(1) Regular room, dietary and nursing services, social services and other services required to meet certification standards, medical and surgical supplies and the use of equipment and facilities.

(2) General nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(3) Items furnished routinely and uniformly to residents, such as resident gowns, water pitchers, basins and bedpans.

(4) Items furnished, distributed to residents or used individually by residents in small quantities such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories and tongue depressors.

(5) Reusable items furnished to residents, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

(6) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

(7) Basic laundry services.

(8) Nonemergency transportation.

(9) Beauty and barber services.

(10) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or maintain the resident's physical and social capacities.

(d) Nursing facilities will receive payment for allowable costs in four general cost centers:

(1) Resident care costs.

(2) Other resident related costs.

(3) Administrative costs.

(4) Capital costs.

(e) Within the limits of this subchapter, allowable costs for purposes of cost reporting include those costs necessary to provide nursing facility services. These may include costs related to the following:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

(v) Medical director.

(vi) Utilization and medical review.

(vii) Social services.

(viii) Resident activities.

(ix) Volunteer services.

(x) Over-the-counter drugs.

(xi) Medical supplies.

(xii) Physical, occupational and speech therapy.

(xiii) Oxygen.

(xiv) Beauty and barber.

(xv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance, including the repair, maintenance and service of movable property.

(v) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility.

(vii) Advertising.

(viii) Travel/entertainment.

(ix) Telephone.

(x) Insurance.

(xi) Interest other than that disallowed under § 1187.59(a)(24) (relating to nonallowable costs).

(xii) Legal fees.

(xiii) Amortization—administrative costs.

(xiv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in connection with an activity identified in this paragraph.

(4) *Capital costs.*

(i) Assigned cost of fixed property.

(ii) Acquisition cost of major movable property.

(iii) Real estate tax cost.

Authority

The provisions of this § 1187.51 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.51 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial pages (351453) to (351454) and (320623).

Cross References

This section cited in 55 Pa. Code § 1187.57 (relating to selected capital cost policies).

§ 1187.52. Allowable cost policies.

(a) The Department will incorporate a nursing facility's direct and indirect allowable costs related to the care of residents into the NIS database. The Department will consider these costs in the setting of prices.

(b) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in reporting allowable costs. For the cost to be allowable, short-term liabilities shall be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

Cross References

This section cited in 55 Pa. Code § 1187.61 (relating to movable property cost policies).

§ 1187.53. Allocating cost centers.

(a) The nursing facility shall allocate costs between nursing facility and residential in accordance with the allocation bases established by the Department as contained in this chapter and the MA-11. If the nursing facility has its own more accurate method of allocation, it may be used only if the nursing facility receives written approval from the Department prior to the first day of the applicable cost report year.

(b) The absence of documentation to support allocation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved changes in bases shall result in disallowances being imposed for each affected line item.

§ 1187.54. Changes in bed complement during a cost reporting period.

(a) When the nursing facility's bed complement changes during a cost reporting period, the allocation bases are subject to verification at audit.

(b) The nursing facility shall keep adequate documentation of the costs related to bed complement changes during a cost reporting period. The nursing facility shall submit a supplemental Schedule C (computation and allocation of allowable cost), which identifies costs being allocated by the required statistical methods for each period of change.

§ 1187.55. Selected resident care and other resident related cost policies.

Policies for selected resident care and other resident related costs are as follows:

(1) *Drug services.*

(i) The costs of nonlegend drugs, such as laxatives, aspirin and antacids that are provided directly by a nursing facility from its own supply are allowable costs if the drugs are medically necessary and administered according to a physician's written order or prescription.

(ii) Costs of legend drugs are not allowable costs.

(iii) Costs related to a pharmacy consultant shall be reported as general administrative costs on the cost report.

(2) *Practitioner and therapy services.*

(i) Costs for practitioner and therapy services which are provided on a contract or salary basis by the nursing facility are allowable costs.

(ii) The direct and indirect costs associated with noncompensable cost centers, such as a pharmacy or space rented or used by an independent practitioner, are not allowable costs.

(3) *Volunteer and donated services of individuals.*

(i) The actual costs that a nursing facility incurs when the nursing facility regularly uses the services of volunteer or religious organizations in positions that are normally held by full-time employes who provide resident care or assist with the operation of the nursing facility are allowable costs. The following conditions and limitations apply:

(A) The costs shall be limited to the fair market value of customary compensation of full-time personnel who perform similar services.

(B) The costs shall be based on regular working hours, excluding overtime.

(C) The actual costs for these services shall be supported by substantiating documentation.

(D) The costs will be reimbursed as part of the net operating costs.

(ii) The Department will recognize costs as allowable for nonpaid workers only if the following conditions are met:

(A) The nonpaid workers shall be members of an organization of nonpaid workers.

(B) Membership of a nonpaid worker in the organization shall be substantiated by adequate documentation in the files of the organization of nonpaid workers.

(C) A legally enforceable agreement between the nursing facility and the organization of nonpaid workers shall exist and establish the nursing facility's obligation to remunerate the organization for services rendered. If the nursing facility's legal obligation to pay the organization of nonpaid workers is nullified by an offsetting legal obligation by the organization of

nonpaid workers to pay or make a contribution to the nursing facility of all or part of the salary liability, the amount paid or contributed by the organization of nonpaid workers is not an allowable cost.

(iii) A payment made by the organization of nonpaid workers to the nursing facility for the nonpaid workers' maintenance, perquisites or fringe benefits shall be used as an offset to the total of the cost actually incurred by the nursing facility.

(iv) Staff services relating to the use of volunteer workers are allowable costs.

(4) *Pastoral services.*

(i) Salary costs for pastoral services rendered directly to residents by professional staff employed by, or under contract with, the nursing facility are allowable costs.

(ii) Costs for a chaplaincy training program and pastoral housing are not allowable costs.

Cross References

This section cited in 55 Pa. Code § 1187.55a (relating to clarification of the term ''written''—statement of policy); and 55 Pa. Code § 1187.59 (relating to nonallowable costs).

§ 1187.55a. Clarification of the term "written"—statement of policy.

(a) The term ''written'' in § 1187.55(1)(i) (relating to selected resident care and other resident related cost policies) includes orders and prescriptions that are handwritten or transmitted by electronic means.

(b) Written orders and prescriptions transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

Source

The provisions of this § 1187.55a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

§ 1187.56. Selected administrative cost policies.

Policies for selected administrative costs are as follows:

(1) *Administrative allowance.*

(i) The allowable administrative costs incurred by a nursing facility to provide services are subject to the following limitation: the allowable administrative costs will be determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs.

(ii) Home office cost allocations and management fees are subject to the following conditions and limitations:

(A) Home office cost allocations and management fees between related parties shall be reported without markup by the nursing facility.

(B) Costs which are not allowable, such as those related to nonworking officers or officers' life insurance, may not be included in home office allocations or management fees.

(C) Documentation relating to home office and management costs shall be provided to the Department's auditors upon request.

(D) Home office allocations, including administratively allowable depreciation and interest costs shall be reported on the administrative line in the MA-11.

(iii) A nursing facility providing nursing, residential and other services shall allocate the total administrative cost to nursing, residential and other services on the basis of a percentage of these costs to the total net operating costs.

(2) *Other interest allowance.*

(i) Other interest is an allowable administrative cost if it is necessary and proper. To be considered allowable, necessary and proper, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of the nursing facility and for a purpose related to resident care. Interest incurred to pay interest is nonallowable.

(ii) Other interest may not exceed that amount which a prudent borrower would pay as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1).

(iii) Other interest is allowable if paid on loans from the nursing facility's donor-restricted funds, the funded depreciation account or the nursing facility's qualified pension fund.

(iv) Moneys borrowed for the purchase or redemption of capital stock will be considered a loan for investment purposes. The interest paid on these borrowed funds is a nonallowable cost. The use of funds by the nursing facility for the redemption of capital stock will be considered as an investment of available funds.

(3) *Investment income.*

(i) Investment income is used to reduce allowable other interest unless the investment income is from one of the following:

(A) Gifts or grants of which the corpus and interest are restricted by the donor.

(B) Funded depreciation maintained in accordance with Federal regulations.

(C) The nursing facility's qualified pension fund, if the interest earned remains in the fund.

(D) Issuer specified designated capital bond funds or debt service reserve funds.

(ii) Investment income on funds found to be used for purposes other than their designated purpose or commingled with other funds will be used to reduce allowable administrative interest expense.

(4) *General administration expenses.*

(i) Salaries of the nursing facility's administrator, comptroller, purchasing agent, personnel director, pharmacy consultant and other persons performing general supervision or management duties are allowable as general administrative costs.

(ii) The salary or compensation costs of owners, operators or persons other than nursing facility employees shall be included as allowable costs only to the extent of their documented time and involvement in the required management of a nursing facility. These costs mean actual payment made during the cost reporting period on a current basis of salary or benefits for services rendered to the nursing facility.

(iii) If a person performs work customarily performed by different or several types of employees, the cost of the salary and other compensation allowable for the person shall be determined by the prorated customary salary and other compensation paid to employees for performing the same types of work. This cost is allowable only if adequate documentation verifying the cost is supplied by the nursing facility.

(iv) The allowable cost for a person performing necessary duties may not exceed the customary compensation and fringe benefits that an employee would normally receive while performing that work.

(5) *Contracted management services.*

(i) In lieu of home office allocations or management fees, a nursing facility may contract with a nonrelated management service. The cost of this contract shall be shown as an administrative cost and may not be allocated among other cost centers.

(ii) Management services contracted with a related party shall be treated as home office allocations.

Source

The provisions of this § 1187.56 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial pages (201543) to (201546).

Cross References

This section cited in 55 Pa. Code § 1187.59 (relating to nonallowable costs); and 55 Pa. Code

§ 1187.57. Selected capital cost policies.

The Department will establish a prospective facility-specific capital rate annually for each nursing facility. That rate will consist of three components: the fixed property component, the movable property component and the real estate tax component.

(1) *Fixed property component*. The Department will base the nursing facility's fixed property component on an assigned cost of $26,000 per allowable bed.

(2) *Movable property component*. The Department will determine the movable property component of each nursing facility's capital rate as follows:

(i) The Department will base the nursing facility's movable property component on the nursing facility's audited cost of major movable property, as set forth in that MA-11.

(ii) Each nursing facility shall report the acquisition cost of all major movable property on the major movable property line of its MA-11 and shall report the cost of minor movable property and the cost of supplies as net operating costs in accordance with § 1187.51 (relating to scope) and instructions for the MA-11.

(3) *Real estate tax cost component*. A nursing facility's real estate tax component will be based solely upon the audited cost of that nursing facility's 12-month real estate tax cost, as set forth on the most recent audited MA-11 cost report available in the NIS database.

Source

The provisions of this § 1187.57 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial pages (320628) to (320630).

§ 1187.58. Costs of related parties.

Costs applicable to services, movable property and supplies, furnished to the nursing facility by organizations related to the nursing facility by common ownership or control shall be included as an allowable cost of the nursing facility at the cost to the related organization. This cost may not exceed the price of comparable services, movable property or supplies that could be purchased elsewhere.

Source

The provisions of this § 1187.58 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial page (201547).

Cross References

This section cited in 55 Pa. Code § 1187.61 (relating to movable property cost policies).

§ 1187.59. Nonallowable costs.

(a) *Nonallowable costs related to expenses and revenues.* The Department will not recognize as allowable costs the expenses or revenues of a nursing facility related to:

(1) Nonworking officers' or owners' salaries.

(2) Fundraising expenses for capital and replacement items exceeding 5% of the amount raised and, for operating expenses and cash flow, fundraising expenses exceeding 10% of the amount raised.

(3) Free care or discounted services.

(4) Parties and social activities not related to resident care.

(5) Organizational memberships not necessary to resident care.

(6) Personal telephone service.

(7) Personal television service.

(8) The direct and indirect costs related to nonallowable cost centers, including gift, flower and coffee shops, homes for administrators or pastors, convent areas and nurses' quarters, except as provided in § 1187.55(3) (relating to selected resident care and other resident related cost policies).

(9) Vending machines.

(10) Charitable contributions.

(11) Employee and guest meals.

(12) Pennsylvania Capital Stock and Franchise Tax.

(13) Income tax.

(14) Ambulance costs.

(15) Promotional advertising, including a yellow page listing larger than a minimum insert.

(16) Late payment penalties.

(17) Taxes based upon net income.

(18) Officers' and directors' life insurance, including life insurance premiums necessary to obtain mortgages and other loans.

(19) Bad debts or contractual adjustments.

(20) Collection expenses associated with bad debts.

(21) Losses on the sale of fixed and movable assets.

(22) Remuneration of any kind for any purpose, including travel expenses for members of the Board of Directors.

(23) Dry cleaning, mending or other specialty laundry services.

(24) Depreciation on fixed or movable property, capital interest, amortization—capital costs and rental expense for fixed property.

(25) Expenses or revenues not necessary to resident care.

(26) Costs, including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of a capital asset—by acquisition or merger—for which payment has previously been made under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395yy) if the sale or purchase was made on or after July 18, 1984.

(27) Letter of credit costs.

(28) Legal expenses related to an appeal or action challenging a payment determination under this chapter until a final adjudication is issued sustaining the nursing facility's appeal. If the nursing facility prevails on some but not all issues raised in the appeal or action, a percentage of the reasonable legal expenses is allowable based upon the proportion of additional reimbursement received to the total additional reimbursement sought on appeal.

(29) Nonstandard or nonuniform fringe benefits.

(30) Return on net equity and net worth.

(b) *Nonallowable costs related to revenue producing items.* In determining the operating costs of a nursing facility, the Department will not allow costs related to:

(1) The sale of laundry and linen service.

(2) The sale of drugs to nonresidents.

(3) The sale of medical and surgical supplies to nonresidents.

(4) The sale of clinical records and abstracts.

(5) The rental of quarters to employees and others.

(6) The rental of space within the nursing facility.

(7) The payments received from clinical specialists.

(8) Discounts on purchases which include trade, quantity and time.

(9) Rebates and refunds of expenses.

(c) *Income that reduces allowable costs.*

(1) Except as provided in § 1187.56(3)(i) (relating to selected administrative cost policies), any form of investment income shall be used to reduce the allowable administrative interest expense.

(2) Grants, gifts and income designated by the donor for specific operating expenses are used to reduce the allowable costs relating to the specific operating expense.

(3) Recovery of insured loss shall be used to reduce the allowable costs relating to the insured loss.

(4) Applicable revenue producing items, other than room and board, shall be used to reduce the related allowable costs.

(5) Payments received under an exceptional DME grant reduce the allowable cost of the major movable property and related services and items in the cost centers where the costs were originally reported in the MA-11.

(d) *Nonallowable direct nursing facility payments.* Costs for prescription drugs, physician services, dental services, dentures, podiatry services, eyeglasses, appliances, X-rays, laboratory services and other materials or services covered by payments, other than MA or Medicare Part A, made directly to nursing facilities, including Medicare Part B, Champus, Blue Cross, Blue Shield or other insurers or third parties, are not allowable in determining net operating costs.

Source

The provisions of this § 1187.59 amended February 8, 2002, effective retroactively November 1, 1999, 32 Pa.B. 734. Immediately preceding text appears at serial pages (201547) to (201549).

Cross References

This section cited in 55 Pa. Code § 1187.51 (relating to scope).

§ 1187.60. Prudent buyer concept.

The purchase or rental by a nursing facility of services, movable property and supplies, including pharmaceuticals, may not exceed the cost that a prudent buyer would pay in the open market to obtain these items, as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1).

Source

The provisions of this § 1187.60 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial page (201549).

Cross References

This section cited in 55 Pa. Code § 1187.61 (relating to movable property cost policies).

§ 1187.61. Movable property cost policies.

(a) *Actual acquisition cost during cost report period.* Except as otherwise specified in this section and subject to §§ 1187.58 and 1187.60 (relating to costs of related parties; and prudent buyer concept), a nursing facility's allowable movable property shall be limited to the nursing facility's actual acquisition cost of movable property placed in service during the cost report period.

(b) *Determination of acquisition cost.* Except in situations where an item of movable property is obtained from a related party, the acquisition cost of that item shall be determined as follows:

(1) Acquisition cost is determined on a per-unit basis.

(2) When an item is purchased, the acquisition cost of that item is equal to the total actual purchase price of the item, regardless of whether the total price is paid in full at the time of purchase or over a period of time, plus the following: any required sales tax, shipping charges and installation charges.

(3) When an item of movable property is leased or rented, the acquisition cost is limited to the lower of: the actual annual lease or rental payments made by the nursing facility; or the imputed purchase price of the item, pro-rated on a straight-line basis over the useful life of the item, as identified in the most recent Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association at the time the item is leased or rented. For purposes of this section, the imputed purchase price of a leased or rented item is the lesser of:

(i) The suggested list price from the manufacturer of the item.

(ii) The actual discounted price of the item available at the time of lease or rental.

(iii) The purchase price for the item set forth in the lease or rental agreement.

(iv) If the lessor is a related party, the related party's acquisition cost as determined in accordance with paragraph (2).

(4) When an item is acquired as the result of a gift or donation, the acquisition cost of that item is deemed to be the appraised depreciated replacement cost of the item provided that, on a date prior to the submission of the MA-11 for the period in which the item is acquired, the nursing facility obtains an appraisal of the item's depreciated replacement cost from a licensed appraiser and submits a copy of the written report of the appraisal to the Department with its MA-11. If the nursing facility fails to obtain an appraisal of the item's depreciated replacement cost from a licensed appraiser within the time period set forth in this section or if the nursing facility fails to submit a copy of the written report of the appraisal to the Department with its MA-11, the acquisition cost of the donated item or gift is deemed to be $0.

(5) When an item is acquired by a trade-in, the acquisition cost of the item shall be the sum of the remaining book value of the item traded-in plus any acquisition cost of the newly acquired item, computed in accordance with paragraphs 2, 3 and 4. The remaining book value of the item shall be determined based upon the useful life of the item, using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(6) When an item is loaned to the nursing facility without charge, the acquisition cost of that item is deemed to be $0.

(7) When an item is covered by a standard express warranty, the cost of that warranty is included in the acquisition cost of the item. The cost of any extended warranty is not included in the acquisition cost of the item.

(8) When an item is acquired from a related party, the acquisition cost of the item shall be determined under § 1187.58.

(c) *Offsets to reported cost of movable property.*

(1) If a nursing facility conveys or otherwise transfers movable property acquired during a cost report period beginning on or after January 1, 2001, to any other person as the result of a sale, trade-in, gift, assignment or other

transaction, an offset will be made against the nursing facility's allowable movable property costs in the year in which the conveyance or transfer occurs. The amount of the offset will be the greater of the amount paid or credited to the nursing facility for the item by the person to whom the item is conveyed or transferred or the remaining book value of the item on the date the item is conveyed or transferred, as determined based upon the useful life of the item, using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(2) If a nursing facility removes from service an item acquired during a cost report period beginning on or after January 1, 2001, before the expiration of the useful life of the item, determined using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, an offset will be made against the nursing facility's allowable movable property costs in the year in which the item is removed from service. The amount of the offset will be the remaining book value of the item, as determined based upon the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(3) If, for movable property acquired during a cost report period beginning on or after January 1, 2001, a nursing facility receives a refund, money or credit under a lease or rental agreement; or money or credit as a result of a trade-in; or money, including insurance proceeds or damages, as the result of recovery of a loss related to that movable property, the amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(4) If a nursing facility fails to liquidate all or part of the acquisition cost of an item reported on the MA-11 during a cost report period beginning on or after January 1, 2001 in accordance with § 1187.52(b) (relating to allowable cost policies) the unliquidated amount will be offset against the nursing facility's allowable movable property cost in a subsequent fiscal period.

(5) If a nursing facility receives a rebate on an item acquired during a cost report period beginning on or after January 1, 2001, the rebate amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(d) Losses incurred on the sale, transfer or disposal of movable property are not allowable costs.

(e) The acquisition cost of movable property that is rented or leased is an allowable cost only if the following requirements are met:

(1) The agreement to rent or lease the movable property shall be in writing, identify each item of movable property that is being rented or leased, identify any other services or supplies that are being provided under the agree-

ment, identify the term of the agreement, the payment intervals, and the amount of the periodic payments and total payments due under the agreement.

(2) The agreement to rent or lease the movable property shall set forth a suggested purchase price for each item of movable property rented or leased.

Source

The provisions of this § 1187.61 adopted February 8, 2002, effective July 1, 2001, 32 Pa.B. 734.

Cross References

This section cited in 55 Pa. Code § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities); and 55 Pa. Code § 1187.154 (relating to exceptional DME grants—general conditions and limitations).

Subchapter F. COST REPORTING AND AUDIT REQUIREMENTS

Sec.

§ 1187.71. Cost reporting.

(a) A nursing facility shall report costs to the MA Program by filing an acceptable MA-11 with the Department. Costs in the MA-11 are:

(1) *Resident care costs.*

(i) Nursing.
(ii) Director of nursing.
(iii) Related clerical staff.
(iv) Practitioners.
(v) Medical director.
(vi) Utilization and medical review.
(vii) Social services.
(viii) Resident activities.
(ix) Volunteer services.
(x) Pharmacy-prescription drugs.
(xi) Over-the-counter drugs.
(xii) Medical supplies.
(xiii) Laboratory and X-rays.
(xiv) Physical, occupational and speech therapy.
(xv) Oxygen.
(xvi) Beauty and barber services.
(xvii) Minor movable property.

(xviii) Other supplies and other resident care costs.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance.

(v) Minor movable property.

(vi) Other supplies and other resident related costs.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility.

(vii) Gift shop.

(viii) Advertising.

(ix) Travel/entertainment.

(x) Telephone.

(xi) Insurance.

(xii) Other interest.

(xiii) Legal fees.

(xiv) Federal/State Corporate/Capital Stock Tax.

(xv) Officers' life insurance.

(xvi) Amortization-administrative costs.

(xvii) Office supplies

(xviii) Minor movable property.

(xix) Other supplies and other administrative costs.

(4) *Capital costs.*

(i) Real estate tax cost.

(ii) Major movable property.

(iii) Depreciation.

(iv) Capital interest.

(v) Rent of nursing facility.

(vi) Amortization—capital costs.

(b) The MA-11 shall identify allowable direct, indirect, ancillary, labor and related party costs for the nursing facility and residential or other facility.

(c) The MA-11 shall identify costs of services, movable property and supplies furnished to the nursing facility by a related party and the rental of the nursing facility from a related party.

(d) The MA-11 shall be based on accrual basis financial and statistical records maintained by the nursing facility. The cost information contained in the

cost report and in the nursing facility's records shall be current, accurate and in sufficient detail to support the reported costs.

(e) An acceptable cost report is one that meets the following requirements:

(1) Applicable items are fully completed in accordance with the instructions incorporated in the MA-11, including the necessary original signatures on the required number of copies.

(2) Computations carried out on the MA-11 are accurate and consistent with other related computations.

(3) The treatment of costs conforms to the applicable requirements of this chapter.

(4) Required documentation is included.

(5) The MA-11 is filed with the Department within the time limits in §§ 1187.73, 1187.75 and 1187.76 (relating to annual reporting; final reporting; and reporting for new nursing facilities).

(f) The nursing facility shall maintain adequate financial records and statistical data for proper determination of costs under the MA Program. The financial records shall include lease agreements, rental agreements, ledgers, books, records and original evidence of cost—purchase requisitions, purchase orders, vouchers, vendor invoices, inventories, time cards, payrolls, bases for apportioning costs and the like—which pertain to the determination of reasonable costs.

(g) Records and other information described in subsection (d) are subject to periodic verification and audit. Costs which are adequately documented are allowable.

(h) The nursing facility shall maintain the records pertaining to each cost report for at least 4 years following the date the nursing facility submits the MA-11 to the Department.

Source

The provisions of this § 1187.71 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial page (201550) to (201552).

Cross References

This section cited in 55 Pa. Code § 1187.73 (relating to annual reporting); and 55 Pa. Code § 1187.75 (relating to final reporting).

§ 1187.72. Cost reporting for Medicare Part B type services.

(a) Nursing facilities shall utilize Medicare as a primary payor resource when appropriate, under § 1187.102 (relating to utilizing Medicare as a resource).

(b) If Medicare is the primary payor resource, the nursing facility shall exclude from allowable costs operating costs incurred in or income derived from the provision of Medicare Part B coverable services to nursing facility residents. The nursing facility shall attach to the MA-11 a copy of the cost report the nursing facility submits to Medicare for the Part B services and, when available, submit a copy of the Medicare final audit, including audit adjustments.

(c) If there is a discrepancy between the costs on the Medicare cost report or, if available, the Medicare audit report, and the adjustments made by the nursing facility on the MA-11 to exclude Medicare Part B costs, the Department will make the necessary adjustments to conform to the Medicare report.

Cross References

This section cited in 55 Pa. Code § 1187.102 (relating to utilizing Medicare as a resource).

§ 1187.73. Annual reporting.

(a) The fiscal year, for purposes of the MA Program for nursing facilities, shall be either January 1 through December 31 or July 1 through June 30 as designated by the nursing facility. The fiscal year designated by the nursing facility may not be changed except in the event of the sale of the nursing facility to a new owner.

(b) A nursing facility shall submit an acceptable MA-11 to the Department within 120 days following the June 30 or December 31 close of each fiscal year as designated by the nursing facility. An acceptable MA-11 is one that meets the requirements in § 1187.71(e) (relating to cost reporting). No request for an extension to file an annual cost report will be granted except in accordance with § 1187.1(d)(2) (relating to policy). The report shall be prepared using the accrual basis of accounting and shall cover a fiscal period of 12 consecutive months.

Cross References

This section cited in 55 Pa. Code § 1187.22 (relating to ongoing responsibilities of nursing facilities); and 55 Pa. Code § 1187.71 (relating to cost reporting).

§ 1187.74. Interim reporting.

A nursing facility may not file interim cost reports.

§ 1187.75. Final reporting.

(a) A nursing facility that enters into a termination agreement or an agreement of sale, or is otherwise undergoing a change of ownership or is withdrawing or being terminated as a nursing facility, shall file an acceptable final MA-11 cost report as well as outstanding annual cost reports with the Department within 90 days of the effective date of the termination, transfer, withdrawal or change of ownership and shall provide financial and statistical records to the Department for auditing. An acceptable MA-11 is one that meets the requirements in § 1187.71(e) (relating to cost reporting).

(b) A nursing facility may request an extension to file its final cost reports as required by subsection (a) of up to 30 days from the date the cost reports are due if the nursing facility's request is received by the Department prior to the expiration of the 60th day of the 90-day period specified in subsection (a); the reasons for the extension request and the amount of time requested are specified; and the

requirements of § 1187.1(d) (relating to policy) are met. Further extensions will not be granted. The denial of a request for an extension is an adverse action appealable in accordance with § 1187.141 (relating to nursing facility's right to appeal and to a hearing). Failure to appeal a denial within the time period provided precludes any appeal or challenge relating to the denial in another proceeding.

Cross References

This section cited in 55 Pa. Code § 1187.22 (relating to ongoing responsibilities of nursing facilities); and 55 Pa. Code § 1187.71 (relating to cost reporting).

§ 1187.76. Reporting for new nursing facilities.

Nursing facilities beginning operations during a fiscal period shall prepare an MA-11 from the date of certification for participation to the end of the nursing facility's fiscal year.

Cross References

This section cited in 55 Pa. Code § 1187.71 (relating to cost reporting).

§ 1187.77. Auditing requirements related to cost report.

(a) The Department will audit acceptable cost reports filed to verify nursing facility compliance with:

(1) This chapter.

(2) Chapter 1101 (relating to general provisions).

(3) The schedules and instructions attached to the MA-11.

(b) A nursing facility shall make financial and statistical records to support the nursing facility's cost reports available to State and Federal representatives upon request.

(c) The Department will conduct audits in accordance with auditing requirements set forth in Federal regulations and generally accepted government auditing standards.

(d) The Department will conduct an audit of each acceptable cost report with an end date of June 30, 1996, or December 31, 1996, and thereafter within 1 year of the Department's acceptance of the cost report. This subsection will not apply if the nursing facility is under investigation by the Attorney General.

(e) The auditor will certify to the Department the allowable cost for the nursing facility to be input into the NIS database for use in determining the median costs.

(f) A nursing facility that has certified financial statements, Medicare intermediary audit reports with adjustments and Medicare reports for the reporting period shall submit these reports with its cost report, at audit or when available.

§ 1187.78. Accountability requirements related to resident personal fund management.

(a) A nursing facility may not require residents to deposit their personal funds with the nursing facility. A nursing facility shall hold, safeguard and account for a resident's personal funds upon written authorization from the resident in accordance with this section and other applicable provisions in State and Federal law.

(b) A resident's personal funds may not be commingled with nursing facility funds or with the funds of a person other than another resident.

(c) A resident's personal funds in excess of $50 shall be maintained in an interest bearing account, and interest earned shall be credited to that account.

(d) A resident's personal funds that do not exceed $50 may be maintained in a noninterest bearing account, interest bearing account or petty cash fund.

(e) Statements regarding a resident's financial record shall be available upon request to the resident or to the resident's legal representative.

(f) The nursing facility shall notify each resident that receives MA benefits when the amount in the resident's personal fund account reaches $200 less than the SSI resource limit for one person.

(g) Within 60 days of the death of a resident, the nursing facility shall convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

(h) The nursing facility may not impose a charge against the personal funds of a resident for an item or service for which payment is made under MA or Medicare.

(i) The nursing facility shall maintain records relating to its management of residents' personal funds for a minimum of 4 years. These records shall be available to Federal and State representatives upon request.

(j) The nursing facility shall purchase a surety bond or otherwise provide assurances of the security of personal funds of the residents deposited with the nursing facility.

Cross References

This section cited in 55 Pa. Code § 1187.22 (relating to ongoing responsibilities of nursing facilities).

§ 1187.79. Auditing requirements related to resident personal fund management.

(a) The Department will periodically audit residents' personal fund accounts.

(b) If discrepancies are found at audit, the nursing facility shall make restitution to the residents for funds improperly handled, accounted for or disbursed. The Department may sanction the nursing facility in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1187.80. Failure to file an MA-11.

(a) Failure by the nursing facility to file a timely MA-11, other than a final MA-11 and annual MA-11s due along with a final MA-11, may result in termination of the nursing facility's provider agreement and will result in adjustment of the nursing facility's per diem rate as provided in this subsection. An MA-11 is considered timely filed if the MA-11 is received within 120 days following the June 30 or December 31 close of each fiscal year as designated by the nursing facility, or if an extension has been granted, within the additional time allowed by the extension. The Department may also seek injunctive relief to require proper filing, as the Department may deem is in the best interest of the efficient and economic administration of the MA program.

(1) *Cost report periods prior to January 1, 2001.*

(i) If an MA-11 is not timely filed, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(2) *Cost report periods beginning January 1, 2001, and thereafter.*

(i) If an MA-11 is not timely filed, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate reduction will begin the first day of the next month and remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate reduction will begin the first day of the next month and remain in effect until an acceptable MA-11 is filed with the Department.

(b) If a nursing facility fails to file a timely final MA-11 and outstanding annual MA-11s:

(1) The net operating components of the nursing facility's per diem rate will be determined on the basis of the nursing facility's peer group medians, prior to the percent of median adjustment in accordance with § 1187.96 (relating to price and rate setting computations), for the last fiscal period for which the nursing facility has an acceptable MA-11 on file.

(2) The capital component of the nursing facility's per diem rate will be set at $0.

Source

The provisions of this § 1187.80 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial page (201555) to (201556).

Subchapter G. RATE SETTING

Sec.

Cross References

This subchapter cited in 55 Pa. Code § 1189.91 (relating to per diem rates for county nursing facilities).

§ 1187.91. Database.

The Department will set rates for the case-mix payment system based on the following data:

(1) *Net operating costs.*

(i) The net operating prices will be established based on the following:

(A) Audited nursing facility costs for the 3 most recent years available in the NIS database adjusted for inflation. This database includes audited MA-11 cost reports that are issued by the Department on or before March 31 of each July 1 price setting period.

(B) If a nursing facility that has participated in the MA Program for 3 or more consecutive years has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use reported costs, as adjusted to conform to Department regulations, for those years not audited

within 15 months of the date of acceptance, until audits have been completed and are available in the NIS database for price setting.

(C) If a nursing facility, that has not participated in the MA Program for 3 or more consecutive years, has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use all available audited cost reports in the NIS database.

(D) For net operating prices effective on or after July 1, 2001, the Department will revise the audited costs specified in clauses (A)—(C) by disregarding audit adjustments disallowing or reclassifying to capital costs, the costs of minor movable property (as defined in § 1187.2 (relating to definitions), effective on July 1, 2001) or linens reported as net operating costs on cost reports for fiscal periods beginning prior to January 1, 2001. The Department will not adjust the audited statistics when revising the nursing facility audited resident care, other resident care and administrative allowable costs to disregard the adjustments relating to minor movable property and linen costs. After revising the audited costs to disregard these adjustments, the Department will recalculate the maximum allowable administrative cost, and will disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i) (relating to selected administrative cost policies).

(ii) Subparagraph (i)(B) does not apply if a nursing facility is under investigation by the Office of Attorney General. In this situation, the Department will use a maximum of the three most recent available audited cost reports in the NIS database used for price setting.

(iii) A cost report for a period of less than 12 months will not be included in the NIS database used for each price setting year.

(iv) Prior to price setting, cost report information will be indexed forward to the 6th month of the 12-month period for which the prices are set. The index used is the 1st Quarter issue of the CMS Nursing Home Without Capital Market Basket Index.

(v) Total facility and MA CMI averages from the quarterly CMI reports will be used to determine case-mix adjustments for each price-setting and rate-setting period as specified in § 1187.96(a)(1)(i) and (5) (relating to price- and rate-setting computations).

(2) *Capital costs*.

(i) *Fixed property component*. The fixed property component of a nursing facility's capital rate will be based upon the total assigned cost of the nursing facility's allowable beds.

(ii) *Movable property component*. The movable property component of a nursing facility's capital rate will be based upon the audited costs of the nursing facility's major movable property as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

(iii) *Real estate tax cost component*. The real estate tax component of a nursing facility's capital rate will be based upon the nursing facility's actual audited real estate tax costs as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

Authority

The provisions of this § 1187.91 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.91 amended February 8, 2002, effective July 1, 2001, except for the limited extent specified in paragraph (1)(iv)(D) applies to cost reports for fiscal period starting on or after January 1, 2001, 32 Pa.B. 734; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial pages (320642) to (320644).

Cross References

This section cited in 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations); 55 Pa. Code § 1187.98 (relating to phase-out median determination); and 55 Pa. Code § 1187.107 (relating to limitations on resident care and other resident related cost centers).

§ 1187.92. Resident classification system.

(a) The Department will use the RUG-III to adjust payment for resident care services based on the classification of nursing facility residents into 44 groups.

(b) Each resident shall be included in the RUG-III category with the highest numeric CMI for which the resident qualifies.

(c) The Department will use the RUG-III nursing CMI scores normalized across all this Commonwealth's nursing facility residents.

(d) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix A, the RUG-III nursing CMI scores and the PA normalized RUG-III index scores.

(e) The PA normalized RUG-III index scores will remain in effect until a subsequent notice is published in the *Pennsylvania Bulletin*.

(f) Resident data for RUG-III classification purposes shall be reported by each nursing facility under § 1187.33 (relating to resident data reporting requirements).

§ 1187.93. CMI calculations.

The Pennsylvania Case-Mix Payment System uses the following CMI calculations:

(1) An individual resident's CMI shall be assigned to the resident according to the RUG-III classification system.

(2) The facility MA CMI shall be the arithmetic mean of the individual CMIs for MA residents identified on the nursing facility's CMI report for the

picture date. The facility MA CMI shall be used for rate determination under § 1187.96(a)(5) (relating to price and rate-setting computations.) If there are no MA residents identified on the CMI report for a picture date, the Statewide average MA CMI shall be substituted for rate determination under § 1187.96(a)(5).

(3) The total facility CMI is the arithmetic mean of the individual resident CMIs for all residents, regardless of payor, identified on the nursing facility's CMI report for the picture date. The total facility CMI for the February 1 picture date shall be used for price and rate setting computations as specified in § 1187.96(a)(1)(i).

(4) Picture dates that are used for rate setting beginning July 1, 2010, and thereafter will be calculated based on the RUG versions and CMIs set forth in Appendix A.

Authority

The provisions of this § 1187.93 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.93 amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630. Immediately preceding text appears at serial pages (354214) to (354215).

Cross References

This section cited in 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations).

§ 1187.94. Peer grouping for price setting.

To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program into 14 mutually exclusive groups as follows:

(1) Nursing facilities participating in the MA Program, except those nursing facilities that meet the definition of a special rehabilitation facility or hospital-based nursing facility, will be classified into 12 mutually exclusive groups based on MSA group classification and nursing facility certified bed complement.

(i) Effective for rate setting periods commencing July 1, 2004, the Department will use the MSA group classification published by the Federal Office of Management and Budget in the OMB Bulletin No. 99-04 (relating to revised definitions of Metropolitan Areas and guidance on uses of Metropolitan Area definitions), to classify each nursing facility into one of three MSA groups or one non-MSA group.

(ii) The Department will use the bed complement of the nursing facility on the final day of the reporting period of the most recent audited MA-11 used in the NIS database to classify nursing facilities into one of three bed complement groups.

(iii) The Department will classify each nursing facility into one of the following 12 peer groups:

Peer Group #	*MSA Group*	*# Beds*
1	A	> or = 270
2	A	120—269

Peer Group #	*MSA Group*	*# Beds*
3	A	3—119
4	B	> or = 270
5	B	120—269
6	B	3—119
7	C	> or = 270
8	C	120—269
9	C	3—119
10	non-MSA	> or = 270
11	non-MSA	120—269
12	non-MSA	3—119

(iv) A peer group with fewer than seven nursing facilities will be collapsed into the adjacent peer group with the same bed size. If the peer group with fewer than seven nursing facilities is a peer group in MSA B or MSA C and there is a choice of two 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.

(v) 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 subparagraph (iv).

(2) To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program that meet the definition of a special rehabilitation facility into one peer group, peer group number 13. Regardless of the number of facilities in this peer group, the Department will not collapse the peer group of special rehabilitation facilities.

(i) Effective November 1, 2011, the Department will establish peer group medians and prices for facilities classified as special rehabilitation facilities on or before July 1, 2000, by using data from only the nursing facilities classified as special rehabilitation facilities on or before July 1, 2000.

(ii) Effective November 1, 2011, the Department will establish peer group medians and prices for facilities classified as special rehabilitation facilities after July 1, 2000, by using data from all nursing facilities classified as special rehabilitation facilities.

(3) To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program that meet the definition of a hospital-based nursing facility into one peer group, peer group number 14. Regardless of the number of facilities in this peer group, the Department will not collapse the peer group of hospital-based nursing facilities.

(4) Once nursing facilities have been classified into peer groups for price setting, the nursing facility costs will remain in that peer group until prices are rebased, unless paragraph (5) applies.

(5) Paragraph (3) sunsets on the date that amendments are effective in Chapter 1163 (relating to inpatient hospital services), to allow for the inclusion of costs previously allocated to hospital-based nursing facilities. Subsequent to the effective date of the amendments to Chapter 1163, the Department will classify hospital-based nursing facilities in accordance with paragraph (1).

Authority

The provisions of this § 1187.94 amended under sections 201(2), 206(2), 403(b), 443.1 and 454 of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b), 443.1 and 454).

Source

The provisions of this § 1187.94 amended August 12, 2005, effective July 1, 2004, 35 Pa.B. 4612; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782; amended June 6, 2014, effective November 1, 2011, 44 Pa.B. 3322. Immediately preceding text appears at serial pages (358351) to (358353).

Cross References

This section cited in 55 Pa. Code § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities); and 55 Pa. Code § 1187.98 (relating to phase-out median determination).

§ 1187.95. General principles for rate and price setting.

(a) Prices will be set prospectively on an annual basis during the second quarter of each calendar year and be in effect for the subsequent July 1 through June 30 period.

(1) Peer group prices will be established for resident care costs, other resident related costs and administrative costs.

(2) If a peer group has an even number of nursing facilities, the median peer group price determined will be the arithmetic mean of the costs of the two nursing facilities holding the middle position in the peer group array.

(3) If a nursing facility changes bed size or MSA group, the nursing facility will be reassigned from the peer group used for price setting to peer group based on bed certification and MSA group as of April 1, for rate setting.

(4) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix B, the peer group prices for each peer group.

(b) Rates will be set prospectively each quarter of the calendar year and will be in effect for 1 full quarter. Net operating rates will be based on peer group prices as limited by § 1187.107 (relating to limitations on resident care and other

resident related cost centers). The nursing facility per diem rate will be computed as defined in § 1187.96(e) (relating to price- and rate-setting computations). Resident care peer group prices will be adjusted for the MA CMI of the nursing facility each quarter and be effective on the first day of the following calendar quarter.

Authority

The provisions of this § 1187.95 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.95 amended May 30, 1997, effective May 31, 1997, and apply retroactively to January 1, 1996, 27 Pa.B. 2636; amended November 2, 2001, effective November 3, 2001, 31 Pa.B. 6048; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (313026), (287611) to (287612) and (315067).

§ 1187.96. Price- and rate-setting computations.

(a) Using the NIS database in accordance with this subsection and § 1187.91 (relating to database), the Department will set prices for the resident care cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total resident care cost for each cost report will be 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.

(ii) The case-mix neutral total resident care cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the case-mix neutral resident care cost per diem for the cost report year.

(iii) The Department will calculate the 3-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.

(2) The average case-mix neutral resident care cost per diem for each nursing facility will be arrayed within the respective peer groups, and a median determined for each peer group.

(3) For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price will be the phase-out median as determined in accordance with § 1187.98 (relating to phase-out median determination).

(4) The median of each peer group will be multiplied by 1.17, and the resultant peer group price assigned to each nursing facility in the peer group.

(5) The price derived in paragraph (4) for each nursing facility will be limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers) and the amount will be multiplied each quarter by the respective nursing facility MA CMI to determine the nursing facility resident care rate. The MA CMI picture date data used in the rate determination are as follows: July 1 rate—February 1 picture date; October 1 rate—May 1 picture date; January 1 rate—August 1 picture date; and April 1 rate—November 1 picture date.

(6) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the resident care rate used to establish the nursing facility's case-mix per diem rate will be a blended resident care rate.

(i) The nursing facility's blended resident care rate for the 2010-2011 rate year will equal 75% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (iv) plus 25% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (iv).

(ii) The nursing facility's blended resident care rate for the 2011-2012 rate year will equal 50% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 50% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iii) The nursing facility's blended resident care rate for the 2012-2013 rate year will equal 25% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 75% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iv) For the rate year 2010-2011, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of the rate year (July 1, 2010—September 30, 2010), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.01 44-group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent comprehensive resident assessment.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2010, and ending September 30, 2010, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.75 and the nursing facility's 5.12 resident care rate multiplied by 0.25.

(B) For the remaining 3 quarters of the 2010-2011 rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the 3 remaining quarters of the rate year will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.75 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.25.

(v) For rate years 2011-2012 and 2012-2013, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of each rate year (July 1—September 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior April 1st

quarter 5.01 resident care rate by the percentage change between the nursing facility's current 5.12 resident care rate and the nursing facility's prior April 1st quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current 5.12 resident care by the nursing facility's April 1st quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2011, and ending September 30, 2011, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.50 and the nursing facility's 5.12 resident care rate multiplied by 0.50.

(IV) The nursing facility's blended resident care rate for the quarter beginning July 1, 2012, and ending September 30, 2012, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.25 and the nursing facility's 5.12 resident care rate multiplied by 0.75.

(B) For the remaining 3 quarters of each rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) For the remaining 3 quarters of rate year 2011-2012 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.50 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.50.

(IV) For the remaining 3 quarters of rate year 2012-2013 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the

sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.25 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.75.

(7) Beginning with rate year 2013-2014, and thereafter, the Department will calculate each nursing facility's resident care rate in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(b) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the other resident related cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total other resident related cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the other resident related cost per diem for the cost report year.

(ii) The Department will calculate the 3-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.

(2) The average other resident related cost per diem for each nursing facility will be arrayed within the respective peer groups and a median determined for each peer group.

(3) For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the other resident related price will be the phase-out median as determined in accordance with § 1187.98.

(4) The median of each peer group will be multiplied by 1.12, and the resultant peer group price assigned to each nursing facility in the peer group. This price for each nursing facility will be limited by § 1187.107 to determine the nursing facility other resident related rate.

(c) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the administrative cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total actual resident days for each cost report will be adjusted to a minimum 90% occupancy, if applicable, in accordance with § 1187.23 (relating to nursing facility incentives and adjustments).

(ii) The total allowable administrative cost for each cost report will be divided by the total actual resident days, adjusted to 90% occupancy, if applicable, to obtain the administrative cost per diem for the cost report year.

(iii) The Department will calculate the 3-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

(2) The average administrative cost per diem for each nursing facility will be arrayed within the respective peer groups and a median determined for each peer group.

(3) For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the administrative price will be the phase-out median as determined in accordance with § 1187.98.

(4) The median of each peer group will be multiplied by 1.04, and the resultant peer group price will be assigned to each nursing facility in the peer group to determine the nursing facility's administrative rate.

(d) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set a rate for the capital cost category for each nursing facility by adding the nursing facility's fixed property component, movable property component and real estate tax component and dividing the sum of the three components by the nursing facility's total actual resident days, adjusted to 90% occupancy, if applicable.

(1) The Department will determine the fixed property component of each nursing facility's capital rate as follows:

(i) The Department will multiply the total number of the nursing facility's allowable beds as of April 1, immediately preceding the rate year, by $26,000 to determine the nursing facility's allowable fixed property cost.

(ii) The Department will multiply the result by the financial yield rate.

(2) The Department will determine the movable property component of each nursing facility's capital rate based on the audited actual costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database in accordance with § 1187.91. This amount is referred to as the nursing facility's allowable movable property cost.

(3) The Department will determine 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 in the most recent audited MA-11 cost report available in the NIS database.

(e) The following applies to the computation of nursing facilities' per diem rates:

(1) The nursing facility per diem rate will be computed by adding the resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

(2) For each quarter of the 2006-2007 and 2007-2008 rate-setting years, the nursing facility per diem rate will be computed as follows:

(i) *Generally*. If a nursing facility is not a new nursing facility or a nursing facility experiencing a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with subsections (a)—

(d) and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(ii) *New nursing facilities*. If a nursing facility is a new nursing facility for purposes of § 1187.97(1) (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(1), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iii) *Nursing facilities with a change of ownership and reorganized nursing facilities*. If a nursing facility undergoes a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(2), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iv) *Budget adjustment factor*. The budget adjustment factor for the rate year will be determined in accordance with the formula set forth in the Commonwealth's approved State Plan.

(3) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the nursing facility per diem rate will be computed by adding the blended resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

Authority

The provisions of this § 1187.96 amended under sections 201(2), 206(2), 403(b), 443.1(5) and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b), 443.1(5) and 454).

Source

The provisions of this § 1187.96 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734; amended November 11, 2005, effective July 1, 2005, 35 Pa.B. 6232; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782; amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630; corrected February 3, 2012, effective February 5, 2011, 42 Pa.B 673. Immediately preceding text appears at serial pages (358354) to (358361).

Notes of Decisions

Nursing facilities alleged that legislative bill authorizing Department of Public Welfare to adopt regulations to control increases in payment rates to nursing facilities was unconstitutional and Department regulations adopted under such authority were void; legislative standards in the State Welfare Code and Federal Medicaid Act properly delegate lawmaking power to Department and are adequate to guide and restrain its discretion in establishing payment methodology. *Christ v. Department of Public Welfare*, 911 A.2d 624, 642—643 (Pa. Cmwlth. 2006).

Cross References

This section cited in 55 Pa. Code § 1187.80 (relating to failure to file an MA-11); 55 Pa. Code § 1187.93 (relating to CMI calculations); 55 Pa. Code § 1187.91 (relating to database); 55 Pa. Code § 1187.95 (relating to general principles for rate and price setting); 55 Pa. Code § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities); 55 Pa. Code § 1187.98 (relating to phase-out median determination); 55 Pa. Code § 1187.104 (relating to limitations on payment for reserved beds); and 55 Pa. Code § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities.

The Department will establish rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities as follows:

(1) *New nursing facilities.*

(i) The net operating portion of the case-mix rate is determined as follows:

(A) A new nursing facility will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under § 1187.33 (relating to resident data and picture date reporting requirements) is used in a rate determination under § 1187.96(a)(5) (relating to price- and rate-setting computations). Beginning, July 1, 2010, the Statewide average MA CMI assigned to a new nursing facility will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent classifiable assessments of any type. When a new nursing facility has submitted assessment data under § 1187.33, the CMI values used to determine the new nursing facility's total facility CMIs and MA CMI will be the RUG-III version 5.12 44 group values and the resident assessment that will be used for each resident will be the most recent classifiable assessment of any type.

(B) The nursing facility will be assigned to the appropriate peer group. The peer group price for resident care, other resident related and administrative costs will be assigned to the nursing facility until there is at least one audited nursing facility cost report used in the rebasing process. Beginning July 1, 2010, a new nursing facility will be assigned the peer group price for resident care that will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent classifiable assessments of any type.

(ii) The three components of the capital portion of the case-mix rate are determined as follows:

(A) *Fixed property component.* The fixed property component will be determined in accordance with § 1187.96(d)(1).

(B) *Movable property component.* The movable property component will be determined as follows:

(I) The nursing facility's acquisition cost, as determined in accordance with § 1187.61(b) (relating to movable property cost policies), for

any new items of movable property acquired on or before the date of enrollment in the MA program, will be added to the nursing facility's remaining book value for any used movable property as of the date of enrollment in the MA program to arrive at the nursing facility's movable property cost.

(II) The nursing facility's movable property cost will then be amortized equally over the first 3 rate years that the nursing facility is enrolled in the MA program to determine the nursing facility's movable property component of the capital rate.

(III) After the first 3 rate years the nursing facility's movable property component will be based on the most recent audited MA-11 cost report available in the NIS database. If no MA-11 is available in the NIS database, the nursing facility will not receive the movable property component of the capital rate.

(C) *Real estate tax component.*

(I) For the first 3 rate years, the new nursing facility real estate tax component will be the nursing facility's annual real estate tax cost as of the date of enrollment in the MA program.

(II) After the first 3 rate years, the real estate tax component will be based on the audited MA-11 cost report available in the NIS database. If no audited MA-11 cost report is available in the NIS database, the nursing facility will not receive the real estate tax component of the capital rate.

(iii) Newly constructed nursing facilities are exempt from the adjustment to 90% occupancy until the nursing facility has participated in the MA Program for one full annual price setting period as described in § 1187.95 (relating to general principles for rate and price setting).

(iv) A new nursing facility is exempt from the occupancy requirements in § 1187.104(1)(ii) (relating to limitations on payment for reserved beds) until a CMI Report for each of the three picture dates used to calculate overall occupancy as set forth in § 1187.104(1)(iii) is available for the rate quarter.

(2) *Nursing facilities with a change of ownership and reorganized nursing facilities*.

(i) *New provider*. The new nursing facility provider will be paid exactly as the old nursing facility provider, except that, 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. Net operating and capital rates for the old nursing facility provider will be assigned to the new nursing facility provider.

(ii) If a county nursing facility has a change of ownership from county ownership to a nonpublic nursing facility provider, the nursing facility will be assigned to the appropriate peer group in accordance with § 1187.94 (relating to peer grouping for price setting) and the per diem rate for the nursing facility will be calculated as follows:

(A) The net operating portion of the case-mix rate is determined in accordance with § 1187.96 using the peer group price for resident care, other resident related and administrative costs until a nursing facility's cost report submitted by the new nursing facility provider is audited for use in the rebasing process.

(B) The capital portion is determined using only the fixed property component to the extent the facility is eligible for the capital portion of the case mix rate, in accordance with § 1187.96(d)(1), until a nursing facility's cost report submitted by the new nursing facility provider is audited for use in the rebasing process.

(iii) *Transfer of data.* Resident assessment data will be transferred from the old nursing facility or the county nursing facility provider number to the new nursing facility provider number. The old nursing facility's or county nursing facility's MA CMI will be transferred to the new nursing facility provider.

(iv) *Movable property cost policies.*

(A) The acquisition costs of items acquired by the old nursing facility provider or county nursing facility on or before the date of sale are costs of the old nursing facility provider or county nursing facility, and not the new nursing facility provider.

(B) Regardless of the provisions of any contract of sale, the amount paid by the new nursing facility provider to acquire or obtain any rights to items in the possession of the old nursing facility provider or county nursing facility is not an allowable cost.

(C) If the new nursing facility provider purchases an item from the old nursing facility provider or county nursing facility, the cost of that item is not an allowable cost for cost reporting or rate setting purposes.

(D) If the new nursing facility provider rents or leases an item from the old nursing facility provider or county nursing facility, the cost of renting or leasing that item is not an allowable cost for cost reporting or rate setting purposes.

(3) *Former prospective payment nursing facilities.* A nursing facility that received a prospective rate prior to the implementation of the case-mix payment system will be treated as a new nursing facility under paragraph (1) for the purpose of establishing a per deim rate.

Authority

The provisions of this § 1187.97 amended under sections 201(2), 206(2), 403(b) and 443.1 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1).

Source

The provisions of this § 1187.97 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782; amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630; corrected February 3, 2012, effective February 5, 2011, 42 Pa.B. 673; amended July 18, 2014, effective July 19, 2014, 44 Pa.B. 4498. Immediately preceding text appears at serial pages (360207) to (360209).

Cross References

This section cited in 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations).

§ 1187.98. Phase-out median determination.

(a) For rate years 2006-2007 and 2007-2008, 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:

(1) Peer groups will be established in accordance with §§ 1187.91 and 1187.94 (relating to database; and peer grouping for price setting).

(2) County nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv).

(3) Audited county nursing facilities' costs from the 3 most recent audited cost reports audited in accordance with this chapter, 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) 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:

(1) The Department will establish an interim phase out median for the rate year as specified in subsection (a).

(2) The phase-out median for the 2009-2010 rate year will equal 75% of the interim median calculated in accordance with paragraph (1) plus 25% of the median calculated in accordance with § 1187.96.

(3) The phase-out median for the 2010-2011 rate year will equal 50% of the interim median calculated in accordance with paragraph (1) plus 50% of the median calculated in accordance with § 1187.96.

(4) The phase-out median for the 2011-2012 rate year will equal 25% of the interim median calculated in accordance with paragraph (1) plus 75% of the median calculated in accordance with § 1187.96.

(c) For the rate year, 2012-2013 and thereafter, county nursing facility MA allowable costs will not be used in the rate-setting process for nonpublic nursing facilities.

Authority

The provisions of this § 1187.98 issued under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.98 adopted June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207; amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial page (320655).

Cross References

This section cited in 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations).

Subchapter H. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

Sec.

§ 1187.101. General payment policy.

(a) Payment for nursing facility services will be subject to the following conditions and limitations:

(1) This chapter and Chapter 1101 (relating to general provisions).

(2) Applicable State statutes.

(3) Applicable Federal statutes and regulations and the Commonwealth's approved State Plan.

(b) Payment will not be made for nursing facility services at the MA per diem rate if full payment is available from another public agency, another insurance or health program or the resident's resources.

(c) Payment will not be made in whole or in part for nursing facility services provided during a period in which the nursing facility's participation in the MA Program is terminated.

(d) Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101. In addition, the Department will perform the reviews specified in this chapter for controlling the utilization of nursing facility services.

Cross References

This section cited in 55 Pa. Code § 1187.21 (relating to nursing facility participation requirements).

§ 1187.102. Utilizing Medicare as a resource.

(a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified nursing facility and is authorized by the Medicare Program to

receive nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the nursing facility's MA per diem rate for nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the nursing facility. The Department will not pay more than the maximum coinsurance amount.

(b) If a resident has Medicare Part B coverage, the nursing facility shall use available Medicare Part B resources for Medicare Part B services before payment is made by the MA Program.

(c) The nursing facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible resident because of the limit of the nursing facility's MA per diem rate.

(d) The Department will recognize the Medicare payment as payment in full for each day that a Medicare payment is made during the Medicare-only benefit period.

(e) The cost of providing Medicare Part B type services to MA recipients not eligible for Medicare Part B services which are otherwise allowable costs under this part are reported in accordance with § 1187.72 (relating to cost reporting for Medicare Part B type services).

Cross References

This section cited in 55 Pa. Code § 1187.72 (relating to cost reporting for Medicare Part B type services).

§ 1187.103. Cost finding and allocation of costs.

(a) A nursing facility shall use the direct allocation method of cost finding. The costs will be apportioned directly to the nursing facility and residential or other facility, based on appropriate financial and statistical data.

(b) Allowable operating cost for nursing facilities will be determined subject to this chapter and the *Medicare Provider Reimbursement Manual*, CMS Pub. 15-1, except that if this chapter and CMS Pub. 15-1 differ, this chapter applies.

Authority

The provisions of this § 1187.103 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.103 amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial page (287050).

§ 1187.104. Limitations on payment for reserved beds.

(a) The Department will make payment to a nursing facility for a reserved bed when the resident is absent from the nursing facility for a continuous 24-hour period because of hospitalization or therapeutic leave subject to the limits in subsection (b). A nursing facility shall record each reserved bed for therapeutic leave on the nursing facility's daily census record and MA invoice. When the bed

reserved for a resident who is hospitalized is temporarily occupied by another resident, a nursing facility shall record the occupied bed on the nursing facility's daily MA census record and the MA invoice. During the reserved bed period the same bed shall be available for the resident upon the resident's return to the nursing facility.

(b) The payment for reserved bed days is subject to the following limits:

(1) *Hospitalization*.

(i) 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 1/3 of the nursing 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 of subparagraph (ii).

(ii) A nursing facility's overall occupancy rate shall equal or exceed the following:

(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 must equal or exceed 75%.

(B) Beginning with the 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 must equal or exceed 85%.

(iii) The Department will calculate a nursing facility's overall occupancy rate for a rate quarter as follows:

(A) The Department will identify the picture date for the rate quarter as specified in § 1187.96(a)(5) (relating to price- and rate-setting computations) and the two picture dates immediately preceding this picture date.

(B) The Department will calculate the nursing facility's occupancy rate for each of the picture dates identified in clause (A) 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.

(C) 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 clause (A), 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 clause (A), the nursing facility is not eligible to receive payment for hospital reserve bed days in the rate quarter.

(D) For purposes of this subsection, a valid CMI report is a CMI report that meets the requirements of § 1187.33(a)(5) and (6) (relating to resident data and picture date reporting requirements).

(iv) If the resident's hospital stay exceeds 15 consecutive days, 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.

(v) If the resident's hospital stay is less than or equal to 15 consecutive days, the nursing facility shall readmit the resident to the same bed the resident occupied before the hospital stay regardless whether the nursing facility is eligible for payment for hospital reserved beds under subparagraph (b)(1)(i), if, at the time of readmission, the resident requires the services provided by the nursing facility.

(vi) Hospital reserved bed days may not be billed as therapeutic leave days and may not be billed to the resident if the resident's hospital stay is less than or equal to 15 consecutive days regardless whether the nursing facility is eligible for payment for hospital reserved beds under subparagraph (b)(1)(i).

(2) *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 if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a nursing facility the nursing facility's current per diem rate on file with the Department for a therapeutic leave day.

Source

The provisions of this § 1187.104 amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial pages (320657) to (320658).

Cross References

This section cited in 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements); 55 Pa. Code § 1187.93 (relating to CMI calculations); and 55 Pa. Code § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities).

§ 1187.105. Limitations on payment for prescription drugs.

The Department's per diem rate for nursing facility services does not include prescription drugs. Prescribed drugs for the categorically needy and medically needy are reimbursable directly to a licensed pharmacy in accordance with Chapter 1121 (relating to pharmaceutical services).

§ 1187.106. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents

is certifiable and licensed to provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring nursing facility provider number as long as the transferring nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§ 1187.107. Limitations on resident care and other resident related cost centers.

(a) The Department will set a limit on the resident care peer group price for each nursing facility for each year, using the NIS database as specified in § 1187.91 (relating to database), to the lower of:

(1) The nursing facility resident care peer group price.

(2) One hundred three percent of the nursing facility's average case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility resident care peer group price.

(b) The Department will set a limit on the other resident related peer group price for each nursing facility for each base year, using the NIS database as specified in § 1187.91 to the lower of:

(1) The nursing facility other resident related peer group price.

(2) One hundred three percent of the nursing facility average other resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility other resident related peer group price.

Cross References

This section cited in 55 Pa. Code § 1187.95 (relating to general principles for rate and price setting); and 55 Pa. Code § 1187.96 (relating to price- and rate-setting computations).

§ 1187.108. Gross adjustments to nursing facility payments.

(a) The case-mix payment system is a prospective system. There is no cost settlement under the case-mix payment system.

(b) Certain adjustments may be made which increase or decrease the payment which a nursing facility may have otherwise received. Gross adjustments to nursing facility payments are based on one or more of the following general provisions:

(1) If audit findings result in changing the peer group median and the peer group price, a retrospective gross adjustment is made for each nursing facility in the peer group where the change occurred.

(2) If a nursing facility's MA CMI changes as a result of UMR resident assessment audit adjustments, retrospective gross adjustments shall be made for the nursing facility involved.

(c) Specific adjustments of the gross payments received by a nursing facility may be required by §§ 1187.109—1187.115.

Cross References

This section cited in 55 Pa. Code § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.109. Medicare upper limit on payment.

Nursing facilities shall submit Medicare information on the MA-11. MA payments will not exceed in the aggregate the comparable amount that Medicare would have paid had the Medicare Program reimbursed for the services rendered.

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.110. Private pay rate adjustment.

The MA rate is limited by the nursing facility's private pay rate for the comparable rate period.

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.111. Disproportionate share incentive payments.

(a) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(1) The nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(2) The nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(b) The disproportionate share incentive payments will be based on the following for year 1 of implementation:

	Overall Occupancy	*MA Occupancy (y)*	*Per Diem Incentive*
Group A	90%	$\geq$ 90% y	$2.50
Group B	90%	88% $\leq$ y $<$90%	$1.70
Group C	90%	86% $\leq$ y $<$88%	$1.00
Group D	90%	84% $\leq$ y $<$86%	$0.60
Group E	90%	82% $\leq$ y $<$84%	$0.30
Group F	90%	80% $\leq$ y $<$82%	$0.20

(c) For each year subsequent to year 1 of implementation, disproportionate share incentive payments as described in subsection (b) will be inflated forward

using the Health Care Financing Administration Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(d) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before 210 days of the close of the nursing facility fiscal year.

(e) For the period July 1, 2005, to June 30, 2009, the disproportionate share incentive payment to qualified nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with subsection (c).

(1) For the period commencing July 1, 2005, through June 30, 2006, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2005, or June 30, 2006.

(2) For the period commencing July 1, 2006, through June 30, 2007, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2006, or June 30, 2007.

(3) For the period commencing July 1, 2007, through June 30, 2008, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2007, or June 30, 2008.

(4) For the period commencing July 1, 2008, through June 30, 2009, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2008, or June 30, 2009.

Authority

The provisions of this § 1187.111 amended under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P.S. §§ 201(2), 206(2), 403(b) and 443.1(5)).

Source

The provisions of this § 1187.111 amended November 2, 2001, effective January 1, 1999, 31 Pa.B. 6046; amended June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (287053) to (287055).

Cross References

This section cited in 55 Pa. Code § 1187.23 (relating to nursing facility incentives and adjustments); and 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.112. [Reserved].

Source

The provisions of this § 1187.112 adopted October 13, 1995, effective October 14, 1995, except subsection (b) effective July 1, 1996, 25 Pa.B. 4477; amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734; reserved November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial pages (320661) to (320662).

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.113. Capital component payment limitation.

(a) *Conditions.* The capital component payment for fixed property is subject to the following conditions:

(1) The Department will make the capital component payment for fixed property on new or additional beds only if one of the following applies:

(i) The nursing facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health by August 31, 1982.

(ii) The nursing facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility located within the county.

(2) The Department will not make the capital component payment unless the nursing facility substantially implements the project under 28 Pa. Code Chapter 401 within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) The capital component payment for replacement beds is allowed only if the nursing facility was issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.

(4) The Department will not make the capital component payment unless written approval was received from the Department prior to the construction of the new beds.

(b) *Capital cost reimbursement waivers.* The Department may grant waivers of subsection (a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department will publish a statement of policy under § 9.12 (relating to statements of policy) specifying the criteria that it will apply to evaluate and approve applications for capital cost reimbursement waivers.

Source

The provisions of this § 1187.113 amended February 8, 2002, effective July 1, 2001, 32 Pa.B. 734. Immediately preceding text appears at serial pages (257357) to (257358).

Cross References

This section cited in 55 Pa. Code § 1187.2 (relating to definitions); 55 Pa. Code § 1187.21a (relating to nursing facility exception requests—statement of policy); 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments); 55 Pa. Code § 1187.113a (relating to nursing facility replacement beds—statement of policy); and 55 Pa. Code § 1187.113b (relating to capital cost reimbursement waivers—statement of policy).

§ 1187.113a. Nursing facility replacement beds—statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for replacement beds constructed, licensed or certified after November 29, 1997.

(b) *Purpose.*

(1) Department regulations relating to capital component payments for nursing facilities enrolled and participating in the Commonwealth's Medical Assistance (MA) Program state that capital component payments for replacement beds are allowed only if the nursing facility was ''issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.'' See § 1187.113(a)(3) (relating to capital component payment limitations).

(2) Chapter 7 and all other portions of the Health Care Facilities Act (35 P. S. §§ 448.701—448.712) pertaining to Certificates of Need (CON) sunsetted on December 18, 1996. To allow the Department to continue to make capital component payments for replacement beds for which a nursing facility does not have a CON or letter of nonreviewability, the Department will amend its regulations to specify the conditions under which it will recognize beds as replacement beds for purposes of making capital component payments. Pending the promulgation of these regulations, the Department has issued this section to specify instances in which the Department will make capital component payments for replacement beds.

(c) *Requests for approval of replacement beds.* A nursing facility provider that intends to seek capital component payments under § 1187.113(a)(3) for nursing facility beds constructed, licensed or certified after November 29, 1997, shall submit a written request to the Department for approval of the beds as replacement beds.

(1) The facility shall submit an original and two copies of its request prior to beginning construction of the beds. If a facility began construction of the beds prior to November 29, 1997, the facility shall submit an original and two copies of its request by February 27, 1998, or the date on which the facility requested the Department of Health to issue a license for the beds, whichever date is earlier.

(2) A facility that fails to submit a request under paragraph (1) may not receive capital component payments for the beds.

(d) *Policy regarding approval of replacement beds.*

(1) *Nursing facility beds authorized under a CON dated on or before December 18, 1996.*

(i) The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if the following conditions are met:

(A) The facility has a CON or letter of nonreviewability dated on or before December 18, 1996, authorizing the replacement bed project.

(B) The facility has ''substantially implemented'' its project, as defined in 28 Pa. Code § 401.2 (relating to definitions).

(C) The beds that are being replaced:

(I) Are currently certified.

(II) Are premoratorium beds.

(III) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(ii) If a facility has a CON dated on or before December 18, 1996 authorizing a replacement bed project, but the facility fails to substantially implement its project as defined in 28 Pa. Code § 401.2, the Department will treat the facility as though it does not have a CON, and consider the facility's request under paragraph (2).

(2) *Nursing facility beds not authorized by a CON dated on or before December 18, 1996.* The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if, after applying the guidelines set forth in subsection (e), the Department determines that the following conditions are met:

(i) Construction of the replacement beds is necessary to assure that MA recipients have access to nursing facility services consistent with applicable law. If the Department determines that some, but not all, of the replacement beds are necessary to assure that MA recipients have appropriate access to nursing facility services, the Department may limit its approval to the number of beds it determines are necessary. If the Department limits its approval to some of the beds, the remaining unapproved beds will not qualify for capital component payments.

(ii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be constructed within a 1-mile radius of the existing structure in which the beds that are being replaced are situated.

(iii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be attached or immediately adjacent to the existing structure in which beds that are being replaced are situated if the replacement beds will replace only a portion of the beds in the existing structure.

(iv) The beds that are being replaced:

(A) Are currently certified.

(B) Are premoratorium beds.

(C) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(e) *Guidelines for evaluation of requests to construct replacement beds.* The Department will use the following guidelines, and will consider the following information, as relevant in determining whether to approve replacement beds under subsection (d)(2).

(1) Whether, and to what extent, construction of all the replacement beds is required to ensure the health, safety and welfare of the residents of the facility.

(2) Whether, and to what extent, building code violations or other regulatory violations exist at the facility requiring the construction of all of the replacement beds. If the provider alleges these violations, it shall attach waivers from the relevant regulatory agencies, and explain why the waivers of code violations may not continue indefinitely.

(3) Whether, and to what extent, the facility has considered the development of home and community-based services in lieu of replacing some or all of its beds.

(4) Whether other support services for MA recipients, including home and community-based services, are available in lieu of nursing facility services.

(5) Whether the overall total occupancy and MA occupancy levels of the facility and facilities in the county indicate that there is a need for all or a portion of the replacement beds.

(6) If the provider is proposing to construct a new facility or wing, whether the provider has satisfactorily demonstrated that it would be more costly to renovate the provider's current facility rather than to construct the new facility or wing.

(7) Whether the facility, or section of the facility, which currently contains the beds to be replaced is able to be utilized for another purpose.

(f) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Premoratorium beds—Nursing facility beds that were built under an approved CON dated on or before August 31, 1982, and for which the Department is making a capital component payment under these regulations.

Replacement beds—Nursing facility beds constructed in a new building or structure that take the place of existing beds located in a separate or attached building or structure; or reconstructed or renovated beds within an existing building or structure when the cost of the reconstruction or renovation equals or exceeds 50% of the total facility's appraised value in effect for the rate period in which the request is made.

Source

The provisions of this § 1187.113a adopted November 28, 1997, effective November 29, 1997, 27 Pa.B. 6238.

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.113b. Capital cost reimbursement waivers—statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for existing postmoratorium beds in a nursing facility. This section also applies to participating providers who were granted moratorium waivers under Chapter 1181 (relating to nursing facility care).

(b) *Purpose.* The purpose of this section is to announce the criteria that the Department will apply to evaluate and approve applications for capital cost reimbursement waivers of § 1187.113(a) (relating to capital component payment limitation) and to reaffirm that nursing facilities that were granted waivers under Chapter 1181 continue to receive capital component payments under this chapter. Waivers of § 1187.113(a) will not otherwise be granted except as provided in this section.

(c) *Submission and content of applications.*

(1) An applicant seeking a waiver of § 1187.113(a) shall submit a written application and two copies to the Department at the following address:

Department of Human Services
Bureau of Long Term Care Programs

P. O. Box 2675
Harrisburg, PA 17105-2675
ATTN: MORATORIUM WAIVER REVIEW

(2) The written application shall address the criteria in subsections (d) and (e). If necessary, the application should include supporting documentation.

(d) *Policy regarding additional capital reimbursement waivers.* Section 1187.113(b) authorizes the Department to grant waivers of § 1187.113(a) to permit capital reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department has determined that a waiver of § 1187.113(a) will only be necessary and appropriate when the Secretary or a designee finds that the waiver is in the Department's best interests and will serve to promote the Commonwealth's policy to encourage the growth of home and community-based services available to MA recipients.

(1) The Department will find that a waiver serves to promote the Commonwealth's policy to encourage the growth of MA home and community-based services only if the Department concludes that the following criteria are met:

(i) The application for a waiver is made by or on behalf of a person who has been the legal entity of two MA participating nursing facilities that meet the following conditions:

(A) Have both been owned by the legal entity for at least 3 consecutive years prior to the date of application.

(B) Serve residents from the same primary service area.

(C) Have each maintained an average MA occupancy rate that exceeds the Statewide MA occupancy rate for 3 consecutive years prior to the date of the application.

(D) Are identified in the application.

(ii) The applicant agrees to permanently decertify all beds in and close one of the two nursing facilities identified in its application in consideration of obtaining a waiver to permit capital component payments to the remaining nursing facility identified in the application.

(iii) Closing the nursing facility will not create an access to care problem for day-one MA eligible recipients in the nursing facility's primary service area.

(iv) One or more of the beds decertified as a result of the closing of the nursing facility is a premoratorium bed.

(v) The legal entity is willing and able to transfer all residents that are displaced by the closing of the nursing facility to the legal entity's remaining nursing facility, unless the residents choose and are able to be transferred elsewhere.

(vi) The remaining nursing facility has one or more existing postmoratorium beds.

(vii) The applicant agrees that, as a condition of both obtaining and receiving continuing payment pursuant to the waiver, the remaining nursing

facility will achieve and maintain an MA occupancy rate equal to or greater than the county average MA occupancy rate or the combined average MA occupancy rate (over the past 3 years) of the closed nursing facility and the remaining nursing facility, whichever is higher.

(viii) The applicant agrees that, if the waiver is granted, it will notify the Department in writing at least 90 days prior to the sale, transfer or assignment of a 5% or more ownership interest, as defined in section 1124(a)(3) of the Social Security Act (42 U.S.C.A. § 1320a-3(a)(3)), in the remaining nursing facility.

(ix) The legal entity is not disqualified from receiving a waiver under subsection (e).

(x) The applicant agrees that the waiver is subject to revocation under the conditions specified in subsection (f).

(xi) The applicant agrees that the Bureau of Hearings and Appeals affords an adequate, and appropriate forum in which to resolve disputes and claims with respect to the remaining nursing facility's participation in, and payment under, the MA Program, including claims or disputes arising under the applicant's provider agreement or addendum thereto, and that, in accordance with applicable provisions of 2 Pa.C.S. §§ 501—508 and 701—704 (relating to administrative agency law) and §§ 1101.84 and 1187.141 (relating to provider right of appeal; and missing facility's right to appeal and to a hearing), the applicant will litigate claims pertaining to its remaining facility exclusively in the Bureau of Hearings and Appeals, subject to its right to seek appellate judicial review.

(xii) The applicant agrees that it will not challenge the Department's denial of capital component payments to postmoratorium beds in the remaining nursing facility.

(xiii) The MA Program will experience overall cost savings if the waiver is granted.

(xiv) The proposal is otherwise in the best interests of the Department. In determining whether the proposal is in its best interests, the Department may consider the following:

(A) Whether the legal entity has demonstrated a commitment to serve MA recipients. In making this determination, the Department will consider the MA occupancy rate of all nursing facilities related by ownership or control to the legal entity.

(B) Whether the legal entity has demonstrated a commitment to provide and develop alternatives to nursing facility services, such as home and community-based services.

(C) Whether the legal entity is willing to refer all persons (including private pay applicants) who seek admission to the remaining nursing facility to the Department or an independent assessor for pre-admission screen-

ing, and to agree to admit only those persons who are determined by that screening to be clinically eligible for nursing facility care.

(D) Other information that the Department deems relevant.

(2) If the Department concludes that the criteria specified in paragraph (1) have been met, the Department will grant a waiver to permit capital component payments to the remaining nursing facility. Capital component payments made pursuant to the waiver shall be limited to the number of postmoratorium beds in the remaining nursing facility as of the date the waiver is granted, or the number of premoratorium beds decertified as a result of the closure of the other nursing facility, whichever number is less.

(e) *Disqualification for past history of serious program deficiencies.* The Department will not grant a waiver of § 1187.113(a) if:

(1) The legal entity, any owner of the legal entity or the nursing facility is currently precluded from participating in the Medicare Program or any state Medicaid Program.

(2) The legal entity or any owner of the legal entity, owned, operated or managed a nursing facility at any time during the 3-year period prior to the date of the application and one of the following applies:

(i) The nursing facility was precluded from participating in the Medicare Program or any state Medicaid Program.

(ii) The nursing facility had its license to operate revoked or suspended.

(iii) The nursing facility was subject to the imposition of sanctions or remedies for residents' rights violations.

(iv) The nursing facility was subject to the imposition of remedies based on the failure to meet applicable Medicare and Medicaid Program participation requirements, and the nursing facility's deficiencies immediately jeopardized the health and safety of the nursing facility's residents; or the nursing facility was designated a poor performing nursing facility.

(f) *Waiver revocation.* The Department will revoke a waiver, recover any funds paid under the waiver, or take other actions as it deems appropriate if it determines that:

(1) The applicant failed to disclose information on its waiver application that would have rendered the legal entity or nursing facility ineligible to receive a waiver under subsections (d) and (e).

(2) The legal entity or nursing facility violate any one or more of the agreements in subsection (d)(1)(ii), (v) and (vii)—(xii).

(g) *Policy regarding capital component payments to participating nursing facilities granted waivers under Chapter 1181.* Waivers of the moratorium regulations granted to nursing facilities under Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulation in § 1187.113(a).

(h) *Effectiveness of waivers granted under this section.* Waivers authorized under this section will remain valid only during the time period in which this section is in effect.

(i) *Definitions*. The following words and terms, when used in this section, have the following meanings, unless the content clearly indicate otherwise:

Applicant—A person with authority to bind the legal entity who submits a request to the Department to waive § 1187.113(a) to permit capital component payments to a nursing facility provider for postmoratorium beds.

Day-one MA eligible—An individual who meets one of the following conditions:

(i) Is or becomes eligible for MA within 60 days of the first day of the month of admission.

(ii) Will become eligible for MA upon conversion from payment under Medicare or a Medicare supplement policy, if applicable.

(iii) Is determined by the Department, or an independent assessor, based upon information available at the time of assessment, as likely to become eligible within 60 days of the first day of the month of admission or upon conversion to MA from payment under Medicare, or a Medicare supplement policy, if applicable.

Owner—A person having an ownership interest in a nursing facility enrolled in the MA Program, as defined in section 1124(a) of the Social Security Act.

Legal entity—A person authorized as the licensee by the Department of Health to operate a nursing facility that participates in the MA Program.

Person—An individual, corporation, partnership, organization, association or a local governmental unit, authority or agency thereof.

Post-moratorium beds—Nursing facility beds that were built with an approved CON or letter of nonreviewability dated after August 31, 1982, or nursing facility beds built without an approved CON or letter of nonreviewability after December 18, 1996.

Pre-moratorium beds—Nursing facility beds that were built under an approved CON or letter of nonreviewability dated on or before August 31, 1982, and for which the Department is making capital component payments.

Primary service area—The county in which the nursing facility is physically located. If the provider demonstrates to the Department's satisfaction that at least 75% of its residents originate from another geographic area, the Department will consider that geographic area to be the provider's primary service area.

Source

The provisions of this § 1187.113b adopted June 25, 1999, effective April 17, 1999 or the effective date of an amendment to the Commonwealth's Medicaid State Plan incorporating this statement of policy into the Commonwealth's approved State Plan, whichever date is later, 29 Pa.B. 3218.

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.114. Adjustments relating to sanctions and fines.

Nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.115. Adjustments relating to errors and corrections of nursing facility payments.

Nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

Cross References

This section cited in 55 Pa. Code § 1187.108 (relating to gross adjustments to nursing facility payments).

§ 1187.116. [Reserved].

Source

The provisions of this § 1187.116 adopted May 30, 1997, effective May 31, 1997, and apply retroactively to January 1, 1996, 27 Pa.B. 2636; reserved June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207. Immediately preceding text appears at serial pages (287064) to (287065).

§ 1187.117. Supplemental ventilator care and tracheostomy care payments.

(a) *Supplemental ventilator care payments.*

(1) A supplemental ventilator care payment will be made each calendar quarter, effective July 1, 2012, through June 30, 2014, to nursing facilities subject to the following:

(i) To qualify for the supplemental ventilator care payment, the nursing facility shall satisfy both of the following threshold criteria on the applicable picture date:

(A) The nursing facility shall have a minimum of ten MA-recipient residents who receive medically necessary ventilator care.

(B) The nursing facility shall have a minimum of 10% of their MA-recipient resident population receiving medically necessary ventilator care.

(ii) Under subparagraph (i), the percentage of the nursing facility's MA-recipient residents who require medically necessary ventilator care will be calculated by dividing the total number of MA-recipient residents who receive medically necessary ventilator care by the total number of MA-recipient residents as described in paragraph (2)(i). The result of this calculation will be rounded to two percentage decimal points. (For example, 0.0945 will be rounded to 0.09 (or 9%); 0.1262 will be rounded to 0.13 (or 13%).)

(iii) To qualify as an MA-recipient resident who receives medically necessary ventilator care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use on the Federally-approved PA-specific MDS assessment listed on the nursing facility's CMI report for the applicable picture date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the nursing facility's CMI report for the applicable picture date. MA-pending individuals or those individuals found to be MA eligible after the nursing facility submits a valid CMI report for the picture date as provided under § 1187.33(a)(5) (relating to resident data and picture date reporting requirements) may not be included in the count and may not result in an adjustment of the percent of ventilator dependent MA residents.

(v) The applicable picture dates and the authorization of a quarterly supplemental ventilator care payment are as follows:

Picture Dates	*Authorization Schedule*
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a nursing facility fails to submit a valid CMI report for the picture date as provided under § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care payment.

(2) A nursing facility's supplemental ventilator care payment is calculated as follows:

(i) The supplemental ventilator care per diem is ((number of MA-recipient residents who receive medically necessary ventilator care/total MA-recipient residents) × $69) × (the number of MA-recipient residents who receive medically necessary ventilator care/total MA-recipient residents).

(ii) The amount of the total supplemental ventilator care payment is the supplemental ventilator care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(b) *Supplemental ventilator care and tracheostomy care payment.*

(1) A supplemental ventilator care and tracheostomy care payment will be made each calendar quarter, effective July 1, 2014, to nursing facilities subject to the following:

(i) To qualify for the supplemental ventilator care and tracheostomy care payment, the nursing facility shall satisfy both of the following threshold criteria on the applicable picture date:

(A) The nursing facility shall have a minimum of ten MA-recipient residents who receive medically necessary ventilator care or tracheostomy care.

(B) The nursing facility shall have a minimum of 10% of their MA-recipient resident population receiving medically necessary ventilator care or tracheostomy care.

(ii) Under subparagraph (i), the percentage of the nursing facility's MA-recipient residents who require medically necessary ventilator care or tracheostomy care will be calculated by dividing the total number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care by the total number of MA-recipient residents as described in paragraph (2)(i). The result of this calculation will be rounded to two percentage decimal points. (For example, 0.0945 will be rounded to 0.09 (or 9%); 0.1262 will be rounded to 0.13 (or 13%).)

(iii) To qualify as an MA-recipient resident who receives medically necessary ventilator care or tracheostomy care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use or tracheostomy care on the Federally-approved PA-specific MDS assessment listed on the nursing facility's CMI report for the applicable picture date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the nursing facility's CMI report for the applicable picture date. MA-pending individuals or those individuals found to be MA eligible after the nursing facility submits a valid CMI report for the picture date as provided under § 1187.33(a)(5) may not be included in the count and may not result in an adjustment of the percent of ventilator dependent or tracheostomy care MA residents.

(v) The applicable picture dates and the authorization of a quarterly supplemental ventilator care and tracheostomy care payment are as follows:

Picture Dates	*Authorization Schedule*
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a nursing facility fails to submit a valid CMI report for the picture date as provided under § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care and tracheostomy care payment.

(2) A nursing facility's supplemental ventilator care and tracheostomy care payment is calculated as follows:

(i) The supplemental ventilator care and tracheostomy care per diem is ((number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care/total MA-recipient residents) × $69) × (the number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care/total MA-recipient residents).

(ii) The amount of the total supplemental ventilator care and tracheostomy care payment is the supplemental ventilator care and tracheostomy care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(c) *Waiver to 180-day billing requirement.* If the Department grants a nursing facility a waiver to the 180-day billing requirement, then the MA-paid days that may be billed under the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care payment under subsection (a) or the supplemental ventilator care and tracheostomy care payment under subsection (b). The Department will not retroactively revise the supplemental payment amount under subsections (a) and (b).

(d) *Calculation of quarterly payments.* The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care or supplemental ventilator care and tracheostomy care payments under subsections (a)(2)(ii) and (b)(2)(ii) will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in subsections (a) and (b).

(e) *Quarterly payments.* The supplemental ventilator care or supplemental ventilator care and tracheostomy care payments will be made quarterly in each month listed in subsections (a) and (b).

Authority

The provisions of this § 1187.117 issued under sections 201(2), 206(2), 403(b) and 443.1 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1).

Source

The provisions of this § 1187.117 adopted June 13, 2014, section 1187(a) shall take effect upon publication and apply retroactively from July 1, 2012, through June 30, 2014, section 1187.117(c)—(e) shall take effect upon publication and apply retroactively from July 1, 2012, section 1187.117(b) takes effect July 1, 2014, 44 Pa.B. 3565.

Subchapter I. ENFORCEMENT OF COMPLIANCE FOR NURSING FACILITIES WITH DEFICIENCIES

Sec.
1187.121. Applicability.
1187.122. Requirements.

Cross References

This subchapter cited in 55 Pa. Code § 1187.79 (relating to auditing requirements related to resident personal fund management); 55 Pa. Code § 1187.114 (relating to adjustments relating to sanctions and fines); 55 Pa. Code § 1187.115 (relating to adjustments relating to errors and corrections of nursing facility payments); 55 Pa. Code § 1187.141 (relating to nursing facility's right to appeal and to a hearing); 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities); 55 Pa. Code § 1189.74 (relating to auditing requirements related to resident personal fund management); 55 Pa. Code § 1189.106 (relating to adjustments relating to sanctions and fines); 55 Pa. Code § 1189.107 (relating to adjustments relating to errors and corrections of county nursing facility payments); and 55 Pa. Code § 1189.141 (relating to county nursing facility's right to appeal and to a hearing).

§ 1187.121. Applicability.

(a) This subchapter addresses the application of remedies established by Federal law to be effective July 1, 1995.

(b) The remedies will be applied on the basis of noncompliance found during surveys conducted by the survey agency or audits, reviews or inspections conducted by the Department or the Auditor General's Office.

Source

The provisions of this § 1187.121 adopted October 13, 1995, effective July 1, 1995, 25 Pa.B. 4477.

§ 1187.122. Requirements.

(a) The Department incorporates by reference 42 CFR 488.400—488.456 (published in 59 FR 56243—56250 (November 10, 1994)) or as amended, as the enforcement of compliance regulations for nursing facilities with deficiencies.

(b) Directed in-service training as contained in 42 CFR 488.406 and 488.425 (relating to available remedies; and directed inservice training) or, as amended, may be imposed as a remedy.

Source

The provisions of this § 1187.122 adopted October 13, 1995, effective July 1, 1995, 25 Pa.B. 4477.

Subchapter J. NURSING FACILITY RIGHT OF APPEAL

Sec.
1187.141. Nursing facility's right to appeal and to a hearing.

§ 1187.141. Nursing facility's right to appeal and to a hearing.

(a) A nursing facility has a right to appeal and have a hearing if the nursing facility does not agree with the Department's decision regarding:

(1) The peer group prices established annually by the Department for the peer group in which the nursing facility is included. The nursing facility may appeal the peer group prices only as to the issue of whether the peer group prices were calculated in accordance with § 1187.96 (relating to price and rate setting computations).

(i) A nursing facility may not challenge the validity or accuracy of any adjustment (except as provided in § 1187.141(10)) or any desk or field audit findings relating to the database or total facility CMIs used by the Department in calculating the peer group prices as a basis for its appeal of the peer group prices.

(ii) If more than one nursing facility in a peer group appeals the peer group prices established by the Department, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(2) The findings issued by the Department in a desk or field audit of the nursing facility's MA-11 cost report.

(3) The Department's denial, nonrenewal or termination of the nursing facility's MA provider agreement.

(4) The MA CMI established quarterly by the Department for the facility.

(5) The Department's imposition of sanctions or fines on the nursing facility under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(6) The total facility CMI established annually by the Department for the nursing facility.

(7) The rate established annually by the Department for the nursing facility for resident care cost, other resident related cost, administrative cost and capital cost.

(8) The quarterly adjustment made by the Department to the nursing facility's rate based upon the facility's MA CMI. The facility may appeal the quarterly rate adjustment only as to the issue of whether the quarterly rate adjustment was calculated correctly.

(9) The disproportionate share incentive payment made annually by the Department to the nursing facility. A nursing facility may appeal its disproportionate share incentive payment only as to the issue of whether the Department used the correct number of MA days of care and the correct inflation factor in calculating the facility's payment.

(10) A retrospective gross adjustment made under § 1187.108 (relating to gross adjustments to nursing facility payments), for the peer group in which the nursing facility is included. The nursing facility may appeal the gross adjustment only as to the issue of whether the adjustment was calculated in accordance with a final administrative action or court order.

(i) A nursing facility may not challenge the validity or accuracy of the underlying action or order which resulted in the retrospective gross adjustment.

(ii) If more than one nursing facility in a peer group appeals a retrospective gross adjustment, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(b) A nursing facility appeal is subject to § 1101.84 (relating to provider right of appeal).

(c) A nursing facility's appeal shall be filed within the following time limits:

(1) A nursing facility's appeal of the peer group prices shall be filed within 30 days of the date on which the Department publishes the peer group price in the *Pennsylvania Bulletin*.

(2) A nursing facility's appeal of the decisions listed in subsection (a)(2)—(10) shall be filed within 30 days of the date of the Department's letter transmitting or notifying the facility of the decision.

(d) A nursing facility's appeal shall meet the following requirements:

(1) A nursing facility's appeal shall be in writing, shall identify the decision appealed and, in appeals involving decisions identified in subsection (a)(2)—(10), shall enclose a copy of the Department's letter transmitting or notifying the nursing facility of the decision.

(2) A nursing facility's appeal shall state in detail the reasons why the facility believes the decision is factually or legally erroneous and the specific issues that the facility will raise in its appeal, including issues relating to the validity of Department regulations. In addition, a nursing facility appeal of findings in a desk or field audit report shall identify the specific findings that the facility believes are erroneous and the reasons why the findings are erroneous. Reasons and issues not stated in a nursing facility's appeal shall be deemed waived and will not be considered in the appeal or any subsequent related appeal, action or proceeding involving the same decision. Desk or field audit findings not identified in a nursing facility appeal will be deemed final and will not be subject to challenge in the appeal or any subsequent related appeal, action or proceeding involving the same desk or field audit.

(3) A nursing facility may amend its appeal in order to meet the requirements of paragraph (2). A nursing facility shall file its amended appeal within 90 days of the date of the decision appealed. An amended appeal shall be permitted only if the nursing facility's appeal was filed in accordance with the time limits set forth in subsection (c). No subsequent amendment of an appeal will be permitted except under § 1187.1(d) (relating to policy).

(e) An appeal or an amended appeal shall be mailed to the Executive Director, Office of Hearings and Appeals, Department of Human Services, Post Office Box 2675, Harrisburg, Pennsylvania 17105. The date of filing is the date of receipt of the appeal or amended appeal by the Office of Hearings and Appeals.

(f) The Department may reopen an audit or a prior year's audit if an appeal is filed.

Cross References

This section cited in 55 Pa. Code § 41.3 (relating to definitions); 55 Pa. Code § 1187.75 (relating to final reporting); 55 Pa. Code § 1187.113b (relating to capital cost reimbursement waivers—statement of policy); 55 Pa. Code § 1187.115 (relating to adjustments relating to errors and corrections of nursing facility payments); and 55 Pa. Code § 1187.158 (relating to appeals).

Subchapter K. EXCEPTIONAL PAYMENT FOR NURSING FACILITY SERVICES

Source

The provisions of this Subchapter K adopted February 8, 2002, effective upon publication and apply retroactively to November 1, 1999, 32 Pa.B. 734, unless otherwise noted.

Cross References

This section cited in 55 Pa. Code § 41.3 (relating to definitions); 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities).

§ 1187.151. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Exceptional DME grant or *grant*—Authorization permitting exceptional payments under specified terms to a nursing facility, in addition to the nursing facility's case-mix per diem rate, for nursing facility services that are provided to a specified resident and that involve the use of certain exceptional DME. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the exceptional DME and the related services and items specified in the grant.

Resident—An MA eligible resident of a nursing facility enrolled in the MA Program who, in a request for an exceptional DME grant, is identified as needing exceptional DME.

§ 1187.152. Additional reimbursement of nursing facility services related to exceptional DME.

(a) The necessary, reasonable and prudent costs incurred by a nursing facility related to the purchase or rental, and the use of DME in providing nursing facility services to residents are allowable costs and included in the calculation of the case-mix per diem rates subject to this chapter. Any costs incurred in excess of the costs identified in a grant are not allowable costs under this chapter.

(b) When a nursing facility provides nursing facility services involving exceptional DME to an MA eligible resident, the nursing facility may, in addition to the submission of invoices for payment based upon the nursing facility's case-mix per diem rate, seek authorization for additional payment by requesting a grant from the Department in accordance with § 1187.153(a) (relating to exceptional DME grants—process).

(c) The Department will issue a grant to a nursing facility if the Department determines that all of the following conditions are met:

(1) The nursing facility's request for the grant complies with all applicable Department instructions.

(2) The specified DME is medically necessary as defined in § 1101.21 (relating to definitions).

(3) The DME specified in the nursing facility's request is exceptional DME as defined in § 1187.2 (relating to definitions).

(4) The nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME.

(5) The nursing facility certifies to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

§ 1187.153. Exceptional DME grants—process.

(a) *Requests for exceptional DME grants.*

(1) A nursing facility shall request a grant in writing on forms designated by the Department and completed in accordance with all applicable Department instructions. The request shall be accompanied by the necessary supporting documentation specified in the Department's instructions and submitted to the Department within 30 days from the date on which the nursing facility purchases or rents the DME for which the nursing facility is requesting the grant.

(2) The nursing facility shall provide copies of the nursing facility's request to the resident and the resident's authorized representative, if any, when the nursing facility submits the request to the Department.

(b) *Notification by the Department.* The Department will send written notice of the Department's decision to approve or deny a nursing facility's request for a grant to the nursing facility, the resident and the resident's authorized representative, if any.

Cross References

This section cited in 55 Pa. Code § 1187.152 (relating to additional reimbursement of nursing facility services related to exceptional DME).

§ 1187.154. Exceptional DME grants—general conditions and limitations.

(a) *Scope and effect of an exceptional DME grant.*

(1) A grant authorizes exceptional payments to a nursing facility in addition to the nursing facility's case-mix per diem payment rate for nursing facility services provided to the resident. The amount of the exceptional payments authorized by the grant is deemed to be the necessary, reasonable and prudent cost of the exceptional DME and the related services and items identified in the nursing facility's grant.

(2) A grant does not authorize exceptional payments for nursing facility services that are provided to MA residents other than the resident, nor does it limit costs that are, or must be, incurred by a nursing facility to provide services to any of the nursing facility's residents (including the resident) in accordance with applicable law and regulations.

(b) *Applicability of laws.* Nursing facility services provided by a nursing facility receiving a grant, including services paid by the grant, remain subject to applicable Federal and State laws and regulations, including the laws and regulations governing the MA Program.

(c) *Reporting of exceptional DME costs and grant payments.*

(1) The nursing facility shall report on the MA-11, the costs related to the acquisition of exceptional DME and related services and items paid by a grant. In identifying the nursing facility's allowable costs, the nursing facility shall adjust those reported costs to the necessary, reasonable and prudent cost amounts identified in the nursing facility's grant.

(2) The nursing facility shall offset all payments made by the Department under a grant against the allowable cost of the exceptional DME and related services and items paid by the grant.

(3) The nursing facility shall identify and report in the MA-11, the costs related to the acquisition of exceptional DME and related services and items, the adjustment to the amount identified in the grant, and the offset of the payment made by the Department under the grant using the accrual basis of accounting.

(d) *Payment in full.* A grant does not waive the preclusion on supplementation established by law. Payment made by the Department under a grant is payment in full for nursing facility services involving the exceptional DME and any related services and items. The entire payment for all MA nursing facility services provided to the resident, including the exceptional DME and any related services and items shall include both of the following:

(1) The nursing facility's case-mix per diem rate.

(2) The exceptional payments authorized by the grant.

(e) *Utilization review.* Nursing facility services paid by a grant are subject to utilization review by the Department, including assessments of the resident's continuing need for the exceptional DME.

(f) *Dispute resolution.* A dispute relating to a grant, including a dispute relating to payments which the nursing facility believes are authorized by the grant and a dispute arising from the termination, suspension or recovery actions taken under § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), shall be brought initially and exclusively for adjudication to the Department's Bureau of Hearings and Appeals.

(g) *Records.* In addition to the nursing facility's existing obligations to maintain and provide documents and records, a nursing facility receiving a grant shall maintain and, upon request, provide to the Department additional documents and records as may be necessary for the Department to determine the nursing facility's compliance with this subchapter and the terms of the nursing facility's grant, including documents and records as may be necessary for the Department to determine the maximum allowable cost of the exceptional DME as specified in § 1187.155(b) (relating to exceptional DME grants—payment conditions and limitations).

(h) *Term of the grant.* A grant is effective on the date specified in the nursing facility's grant and ends on the date the grant is terminated under § 1187.157.

(i) *Acquisition, maintenance, use and disposal of exceptional DME.*

(1) A nursing facility shall obtain exceptional DME and related services and items paid by a grant at the lowest practicable cost and shall purchase by means of competitive bidding whenever required by law.

(2) Unless otherwise approved in writing by the Department, a nursing facility may use exceptional DME paid by a grant only as specified by the nursing facility's grant.

(3) Except as specified otherwise in paragraph (5), a nursing facility has title to any exceptional DME and related items purchased by the nursing facility under the grant.

(4) If an item of exceptional DME purchased under a grant is no longer necessary to provide care and services to the resident, and subject to paragraph (2), the nursing facility shall make the item available for the use, as necessary, in the care and treatment of other MA residents of the nursing facility unless directed by the Department to transfer the exceptional DME in accordance with paragraph (5).

(5) Upon termination of a grant, the Department may direct that the nursing facility transfer the exceptional DME and related items to another provider designated by the Department or to the resident. Title to the transferred exceptional DME and related items shall then vest in the designated provider or the resident. If a transfer is required under this paragraph, § 1187.61(c)(1) (relating to movable property cost policies) does not apply.

(6) A nursing facility shall, in accordance with sound business practice, maintain and administer a program for the maintenance, repair, protection, preservation and insurance of exceptional DME paid by a grant.

(7) If a nursing facility is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to exceptional DME paid by a grant, the nursing facility shall, at the Department's direction, use the proceeds to replace, repair or renovate the property involved.

§ 1187.155. Exceptional DME grants—payment conditions and limitations.

(a) *Authorization of exceptional payments.* Exceptional payments authorized by an exceptional DME grant will be paid as follows:

(1) *Periodic payments.* Unless the grant authorizes a lump sum payment under paragraph (2), the grant will authorize exceptional payments to the nursing facility on a specified periodic basis. Authorization for periodic payments will continue during the term of the nursing facility's grant except during a period of suspension as specified in § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

(2) *Lump sum payment.* The grant may authorize a lump sum exceptional payment to the nursing facility if the Department determines that a lump sum payment is in the best interest of the MA Program. The amount of this payment will be based upon and limited by the necessary, reasonable and prudent costs incurred by the nursing facility to purchase exceptional DME and related items.

(b) *Maximum allowable payment.* The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following:

(1) The lower of the nursing facility's costs to acquire the exceptional DME and related services and items; or, in the event the nursing facility is acquiring the exceptional DME or related services and items from a related party as defined in § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the nursing facility.

(2) The applicable MA outpatient fee schedule amount, if any.

(3) Eighty percent of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

(c) *Additional conditions and limitations.* Exceptional payments made by the Department to a nursing facility under a grant are subject to the following:

(1) The conditions and limitations set forth in Chapter 1101 (relating to general provisions), including §§ 1101.64 and 1101.68 (relating to third-party medical resources; and invoicing for services).

(2) The terms of the nursing facility's grant.

Cross References

This section cited in 55 Pa. Code § 1187.154 (relating to exceptional DME grants—general conditions and limitations).

§ 1187.156. Exceptional DME notification and reporting requirements.

(a) *Status reports.* A nursing facility receiving a grant shall submit periodic status reports to the Department as specified in the nursing facility's grant.

(b) *Notices.* A nursing facility receiving a grant shall notify the Department in writing within 5 days of any of the following occurrences:

(1) The resident dies.

(2) The resident ceases to be MA eligible.

(3) The resident is transferred or discharged from the nursing facility, whether or not there is intent to return.

(4) The nursing facility determines, or is advised by the resident's attending physician, that the exceptional DME is no longer medically necessary.

(5) The resident notifies the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(6) The nursing facility ceases to use the exceptional DME or make that DME available to the resident in the course of providing nursing facility services to the resident.

§ 1187.157. Termination or suspension of exceptional DME grants and recovery of exceptional payments.

(a) *Termination or suspension of an exceptional DME grant.*

(1) *Automatic termination.* Any of the following conditions shall cause termination of a nursing facility's grant without further notice or action by the Department:

(i) The resident dies.

(ii) The resident ceases to be MA eligible.

(iii) The resident is transferred or discharged from the nursing facility with no intent to return.

(iv) The resident's attending physician notifies the nursing facility that the exceptional DME is no longer medically necessary.

(v) The resident notifies the Department or the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(vi) The nursing facility is no longer enrolled in the MA Program.

(2) *Termination upon notice.* The Department may terminate a grant upon written notice to the nursing facility if any one or more of the conditions in subparagraphs (i)—(vi) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The Department determines that the exceptional DME is no longer medically necessary.

(ii) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(iii) There is a change in state or federal law or regulations governing payments to MA providers of nursing facility services.

(iv) Exceptional DME payments are no longer authorized under the Commonwealth's approved Medicaid State Plan.

(v) The nursing facility has violated the terms of the grant.

(vi) The nursing facility changes ownership.

(3) *Suspension of grant payments.* The Department may suspend payments under a grant upon written notice to the nursing facility if one or more of the conditions in subparagraphs (i) and (ii) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(ii) The resident is absent from the nursing facility because of therapeutic leave.

(4) *Termination or suspension date.* A termination under paragraph (1) is effective as of the date on which the condition giving rise to the automatic termination first arises. A termination under paragraph (2) is effective on the date specified in the Department's written notice to the nursing facility. A suspension under paragraph (3) is effective on the date and for the period specified in the Department's written notice to the nursing facility.

(5) *Effect of termination.*

(i) Termination of an exceptional DME grant, whether automatic or by written notice, terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident after the termination date.

(ii) Termination of the grant ends the nursing facility's grant and the nursing facility's duty and obligation to comply with the terms of the grant

or the requirements of this subchapter, except as may be otherwise specified in the grant or in this subchapter.

(iii) Termination of a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(6) *Effect of suspension.*

(i) Suspension of payments under a grant terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident for the period specified in the notice of suspension.

(ii) Suspension of payments under a grant does not terminate the nursing facility's grant or the nursing facility's duty and obligation to comply with the terms of the grant or the requirements of this subchapter.

(iii) Suspension of payments under a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(b) *Recovery of exceptional DME grant payments.*

(1) If a grant is terminated or if payments under a grant are suspended, the Department will recover any exceptional payments made to the nursing facility for services provided after the termination date or during the period of suspension.

(2) If the nursing facility violates this subchapter or the terms of its grant, the Department may recover exceptional payments made to the nursing facility in addition to or instead of terminating the nursing facility's grant.

(c) *Rights and remedies.* The rights and remedies available to the Department under this section are in addition to any rights, remedies and sanctions otherwise available to the Department under law and regulation.

Cross References

This section cited in 55 Pa. Code § 1187.154 (relating to exceptional DME grants—general conditions and limitations); 55 Pa. Code § 1187.155 (relating to exceptional DME grants—payment conditions and limitations); and 55 Pa. Code § 1187.158 (relating to appeals).

§ 1187.158. Appeals.

(a) *Appeals.* An appeal may be filed by the resident or the resident's authorized representative, by the nursing facility, or by both, from the Department's decision to deny, terminate or suspend a grant, subject to the following:

(1) If the Department denies a grant because the DME is not exceptional DME, an appeal of the denial may be filed solely on the basis that the DME is exceptional DME as defined in § 1187.2 (relating to definitions).

(2) If the Department automatically terminates a grant under § 1187.157(a)(1) (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), an appeal of the termination may be filed solely on the basis that none of the conditions specified in § 1187.157(a)(1)(i)—(vi) has occurred.

(3) If a resident appeals the denial, termination or suspension of a grant, Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings) applies.

(4) If a nursing facility appeals the denial, termination or suspension of a grant, § 1187.141(b), (d) and (e) (relating to nursing facility's right to appeal and to a hearing) apply.

(5) An appeal from the Department's decision denying a request for a grant shall be received in the Department's Bureau of Hearings and Appeals within 30 days of the date of the Department's written notice.

(6) If the resident or the nursing facility timely appeals the Department's decision to deny, suspend or terminate a grant, the Department's decision is not final until the Department issues a final adjudication on the appeal.

(b) *Effect of decisions.*

(1) *Effect on subsequent grant requests.* The denial or termination of a grant, does not prohibit a nursing facility from submitting a new request for an exceptional DME grant for the same resident, if the nursing facility determines that there has been a change in the resident's condition since the denial or termination.

(2) *Effect on services.*

(i) If the Department determines that DME specified in the nursing facility's request is medically necessary but denies the request because the DME is not exceptional DME, the nursing facility shall, as a part of the nursing facility services that it provides to the resident, provide the DME to the resident, unless the resident refuses the DME, regardless of whether the nursing facility or resident appeals the Department's decision. If the resident refuses the DME, the nursing facility shall notify the Department in accordance with § 1187.22(17) (relating to ongoing responsibilities of nursing facilities).

(ii) If the Department determines that the DME specified in the nursing facility's request is exceptional DME but denies the request because the DME is not medically necessary, the nursing facility may provide the DME and charge the resident in accordance with and subject to applicable Federal and state requirements, including 42 CFR 483.10(c)(8) (relating to resident rights) and § 1101.63(a) (relating to payment in full), if, after receiving actual notice of the Department's denial, the resident requests that the nursing facility provide the DME. If the resident or nursing facility appeals the Department's determination to deny the exceptional DME grant and the appeal is sustained, the nursing facility shall refund any payment made by the resident within 60 days from the date of the Department's final adjudication sustaining the appeal.

(iii) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3), and the resident or the resident's authorized representative appeals the termination or suspension within 10-calendar days of the date on which the Department's notice was mailed, the Department will continue to make payments under the grant pending the outcome of the hearing on the resident's appeal. If, after the hearing, the

Department denies the resident's appeal, the Department will recover any payments made under the grant on or after the termination date or during the period of suspension specified in the Department's notice.

(iv) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3), and the resident or the resident's authorized representative does not appeal the termination or suspension, or appeals more than 10-calendar days from the date on which the Department's notice was mailed, the Department will cease payments under the grant on the termination date or during the period of suspension specified in the Department's notice.

Subchapter L. NURSING FACILITY PARTICIPATION REQUIREMENTS AND REVIEW PROCESS

GENERAL PROVISIONS

BED REQUESTS

Source

The provisions of this Subchapter L adopted June 29, 2012, effective June 30, 2012, 42 Pa.B. 3733, unless otherwise noted.

Cross References

This Subchapter cited in 55 Pa. Code § 1187.21 (relating to nursing facility participation requirements); and 55 Pa. Code § 1189.3 (relating to compliance with regulations governing noncounty nursing facilities).

GENERAL PROVISIONS

§ 1187.161. Applicability.

This subchapter applies to applicants as defined in § 1187.162 (relating to definitions).

§ 1187.162. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Applicant—A legal entity or a person authorized by and acting on behalf of a legal entity who submits a bed request to the Department.

Bed request—A request by an applicant for the Department's approval to increase the number of MA-certified beds in a subject facility that is a provider or a request by an applicant to increase the number of MA-certified beds in the MA Program by enrolling a subject facility as a new provider.

Bed transfer request—A bed request in which the following conditions apply:

(i) The applicant seeks the Department's approval to increase the number of MA-certified beds in a provider.

(ii) The applicant represents that, if the Department approves the request, at least the same number of MA-certified beds will be decertified and closed at a different provider.

(iii) The providers are located in the same county, or the driving distance between providers is no greater than 25 miles if both providers are in MSA Level A, as specified by the Federal Office of Management and Budget in the OMB Bulletin No. 99-04, or no greater than 50 miles in all other cases.

Legal entity—One of the following:

(i) A person who is a licensee of a licensed nursing facility, as authorized by the Department of Health.

(ii) A person proposing to develop or construct a long-term care nursing facility as defined in Chapter 8 of the Health Care Facilities Act (35 P. S. §§ 448.801—448.821).

MA day-one admission rate—The quotient of the number of MA day-one recipients admitted to the subject facility during a 12-month period, divided by the total number of individuals admitted to the nursing facility during the same 12-month period.

MA day-one recipient—An individual who is eligible for nursing facility services under the MA Program or who becomes eligible for nursing facility services under the MA Program within 60 days of the date of the individual's admission to a nursing facility.

MA day-one report—A document displaying admission rates of MA day-one recipients for a 12-month period using data obtained from Federally-approved PA specific MDS submissions for each nursing facility enrolled in the MA Program.

MA occupancy rate—The quotient of the total MA days of care reported in an MA cost report, divided by the total actual days of care reported in the same MA cost report.

Nonpublic nursing facility—A nursing facility other than a county nursing facility or a facility owned or operated by the State or Federal government.

Overall occupancy rate—The quotient of the total actual days of care reported in an MA cost report, divided by the total available days of care reported in the same MA cost report.

Owner—A person having an ownership or control interest, as defined in section 1124(a) of the Social Security Act (42 U.S.C.A. § 1320a-3(a)), in the subject facility.

Person—A natural person, corporation (including associations, joint stock companies and insurance companies), partnership, trust, estate, association, the Commonwealth, and any local government unit, authority and agency thereof.

Primary service area—One of the following:

(i) The county in which the subject facility is or will be physically located.

(ii) The geographic area from which the subject facility draws or is expected to draw at least 75% of its resident population, as determined by the Department.

Proposed project—Any one of the following:

(i) An increase in the number of licensed beds in a provider.

(ii) The construction of a new county or nonpublic nursing facility if there is an expectation that the facility will become a provider.

(iii) The enrollment of a county or nonpublic nursing facility as a provider.

Provider—A licensed county or nonpublic nursing facility that is certified and enrolled as a nursing facility provider in the MA Program.

Receiving provider—The provider identified in a bed transfer request which will increase the number of its MA-certified beds if the bed transfer request is approved. The receiving provider is the subject facility of the bed transfer request.

Related party—A person who is or would be identified as a related party in a subject facility's MA cost report if the person were to provide goods, services or property to the subject facility.

Specialized medical services—Services that require staffing with advance training and need-specific equipment, including services needed by an individual who has severe dementia or traumatic brain injury or who requires a respirator for survival, or who receives bed side hemodialysis. Specialized medical services are not routinely provided in general nursing facilities and do not include the services of a dedicated Alzheimer's unit or infection isolation wing, osteopathic treatment or similar services.

Subject facility—An existing or proposed county or nonpublic nursing facility identified on a bed request that will increase the number of its licensed nursing facility beds or enroll as a provider in the MA Program if the bed request is approved.

Surrendering provider—The provider identified on a bed transfer request which will decertify and close at least the same number of MA-certified beds as the receiving provider identified in the same bed transfer request, if the request is approved.

Cross References

This section cited in 55 Pa. Code § 1187.161 (relating to applicability).

BED REQUESTS

§ 1187.171. Enrollment in the MA Program and expansion of existing providers.

(a) As a condition of participation in the MA Program, an applicant shall submit a bed request to the Department and obtain the Department's advance written approval before increasing the number of MA-certified beds in a subject facility that is a provider, or before applying for the enrollment of a subject facility as a new provider.

(b) As a condition of participation in the MA Program, an applicant shall submit its bed request to the Department prior to beginning a proposed project that involves the construction of a new nursing facility or an expansion of an existing nursing facility.

§ 1187.172. Contents and submission of bed requests.

(a) *Required contents.* An applicant's bed request must contain the following information:

(1) *Ownership information.*

(i) The applicant shall provide the name and address of each person who is any of the following:

(A) The applicant and a description of the applicant's involvement in the proposed project.

(B) The legal entity of the subject facility.

(C) An owner of the subject facility.

(D) A related party involved in the proposed project and a description of the related party's involvement with the project.

(ii) For each person identified, the applicant shall specify whether:

(A) The person is a spouse, parent, child or sibling of another person identified.

(B) During the 3-year period preceding the bed request, the person is or was an owner of a nursing facility, whether or not located in this Commonwealth, and, if so, the name and address of each of the nursing facilities.

(2) *Project overview.*

(i) The applicant shall provide an overview of the proposed project which includes a description of the population and primary service area the applicant intends to serve.

(ii) The applicant shall include a narrative and supporting documentation addressing each criterion in §§ 1187.175 and 1187.176 (relating to criteria for the approval of bed transfer requests; and criteria for the approval

of bed requests other than bed transfer requests), as applicable, and indexed to the criterion being addressed.

(3) *Financial information.*

(i) The applicant shall provide a feasibility or market study and financial projections prepared for the project that identify the following:

(A) Project costs.

(B) Sources of project funds.

(C) Projected revenue sources by payor type.

(D) Specific assumptions used and expected occupancy rates by payor type.

(ii) The applicant shall provide independent audited or reviewed financial statements of the subject facility for the most recent year prior to the fiscal year in which the bed request is filed. If the financial statements are not available for the subject facility, the applicant shall provide independent audited or reviewed financial statements of the legal entity or parent corporation of the subject facility for the most recent year prior to the fiscal year in which the bed request is filed.

(4) *Compliance history.* For each person identified in the ownership information section of the bed request as specified under paragraph (1), an applicant shall specify whether or not any of the following applies, and, if so, the applicant shall attach copies of all documents relating to the applicable action, including notices, orders or sanction letters received from the Federal Centers for Medicare and Medicaid Services or any state Medicaid, survey or licensing agency:

(i) The person is currently precluded or, at any time during the 3-year period preceding the bed request, was precluded from participating in the Medicare Program or any State Medicaid Program.

(ii) The person is or, at any time during the 3-year period preceding the date of the bed request, was a party to, or the owner of a party to a corporate integrity agreement with the Department or the Federal government.

(iii) The person owned, operated or managed a nursing facility, including the subject facility, and, at any time during the 3-year period preceding the date of the bed request, one of the following applies:

(A) The facility was precluded from participating in the Medicare Program or any State Medicaid Program.

(B) The facility had its license to operate revoked or suspended.

(C) The facility was subject to the imposition of civil monetary penalties, sanctions or remedies under State or Federal law for resident rights violations.

(D) The facility was subject to the imposition of remedies based on the failure to meet applicable Medicare and Medicaid Program participation requirements, and the facility's deficiencies were graded as immediate jeopardy to resident health and safety.

(E) The facility was designated a special focus facility by the Federal Centers for Medicare and Medicaid Services, indicating a poor performing facility.

(5) *Certification and authority.*

(i) A bed request shall be signed by the applicant.

(ii) The applicant shall certify that the representations made and the information provided in the bed request are true and correct to the best of the applicant's knowledge, information and belief.

(iii) If the applicant is a person other than the legal entity of the subject facility, the applicant shall certify that the applicant is authorized to submit the bed request on behalf of the legal entity and that the legal entity has reviewed and approved the contents of the bed request.

(b) *Optional information.* In addition to the required content specified under subsection (a), an applicant may include in its bed request whatever information the applicant feels is relevant to or supports its bed request.

(c) *Submission.* An applicant shall submit an original and two copies of its bed request to the Department.

Cross References

This section cited in 55 Pa. Code § 1187.174 (relating to information and data relevant to bed requests); 55 Pa. Code § 1187.175 (relating to criteria for the approval of bed transfer requests); and 55 Pa. Code § 1187.176 (relating to criteria for the approval of bed requests other than bed transfer requests).

§ 1187.173. Review and public process relating to bed requests.

(a) *Groups.* Except as specified in subsection (b), the Department will consider bed requests in two groups, as follows:

(1) Group one will consist of bed requests received January 1 through June 30. Subject to subsection (c), the Department will issue decisions on group one by the following December 31. If the Department receives public comments under subsection (d), the Department may extend the review process an additional 90 days.

(2) Group two will consist of bed requests received from July 1 through December 31. Subject to subsection (c), the Department will issue decisions on group two by the following June 30. If the Department receives public comments under subsection (d), the Department may extend the review process an additional 90 days.

(b) *Bed transfer requests.*

(1) The Department will consider bed transfer requests in the order in which they are received.

(2) Subject to subsection (c), the Department will issue decisions on bed transfer requests within 120 days after the expiration of the public comment period under subsection (d).

(c) *Expedited review.* If an applicant demonstrates to the satisfaction of the Department that good cause exists, the Department, within its sole discretion, may expedite its review and respond to a bed request before the target date, provided that the Department will not respond prior to the close of the applicable public comment period specified in subsection (d).

(d) *Public process.*

(1) *Data book.* The Department will compile and make available on the Department's web site a workbook for each review period containing the following:

(i) Data relating to the availability and cost of MA nursing facility services Statewide and by county.

(ii) Data relating to the availability and cost of home and community-based services Statewide and by county.

(iii) Commonwealth and county demographic data.

(2) *Publication of and public comment period for bed requests.* Following the close of each 6-month request period, the Department will post on the Department's web site a list of bed requests, other than bed transfer requests included in the group under consideration. The Department will make the requests in that group available for review by the public during regular business hours, and will accept written comments related to the requests in the group for a 30-day period following the date that the notice is posted online. Written comments received by the Department and the applicant's responses to the public comments will be posted on the Department's web site.

(i) The group one list will be posted on the Department's web site on or before July 31.

(ii) The group two list will be posted on the Department's web site on or before January 31.

(3) *Publication of and public comment period for bed transfer requests.* No later than 15 calendar days following the last day of each calendar month, a list of the bed transfer requests received by the Department during that calendar month will be posted on the Department's web site. The Department will make the requests listed for that calendar month available for review by the public during regular business hours, and will accept written comments related to the requests for a 15-calendar-day period following the date that the list is posted online. Written comments received by the Department and the applicant's responses to the public comments will be posted on the Department's web site.

Cross References

This section cited in 55 Pa. Code § 1187.174 (relating to information and data relevant to bed requests).

§ 1187.174. Information and data relevant to bed requests.

In reviewing an applicant's bed request, the Department will consider the information provided by the applicant and any public comments received on the request. In addition, the Department may consider information contained in the Department's books and records or obtained from persons other than the applicant that is relevant to the applicant's bed request, including the following:

(1) Data relating to the overall occupancy rates of MA nursing facilities in the primary service area identified in the bed request, the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

(2) Data relating to the MA day-one admission rates and the MA occupancy rates of MA nursing facilities in the primary service area identified in the bed request, the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

(i) The Department will determine the MA day-one admission rate using the most recent MA day-one report completed and posted to the Department's web site prior to January 1 for group one and July 1 for group two as provided under § 1187.173(a) (relating to review and public process relating to bed requests).

(ii) The Department will determine the MA day-one admission rate using the most recent MA day-one report completed and posted to the Department's web site prior to the application date of the bed transfer request.

(3) Data relating to the availability of home and community-based services in the primary service area identified in the bed request, the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

(4) Data relating to the demographics of the primary service area identified in the bed request, the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

(5) Data relating to admissions and discharges at MA nursing facilities in the primary service area identified in the bed request, the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

(6) Data relating to the compliance history of the subject facility and the persons identified in the ownership information section of the bed request, as specified under § 1187.172(a)(1) (relating to contents and submission of bed requests).

(7) If the applicant is proposing to provide specialized medical services in the subject facility, data relating to the availability of those services in the pri-

mary service area identified in the bed request the county in which the subject facility is or will be located and, in the case of a bed transfer request, the county in which the surrendering provider is located.

Cross References

This section cited in 55 Pa. Code § 1187.175 (relating to criteria for the approval of bed transfer requests).

§ 1187.175. Criteria for the approval of bed transfer requests.

(a) Upon consideration of the information specified in § 1187.174 (relating to information and data relevant to bed requests), the Department may approve a bed transfer request only if the following are satisfied:

(1) The bed transfer request contains the information required under § 1187.172(a) (relating to contents and submission of bed requests).

(2) The receiving provider agrees to achieve and maintain an MA day-one admission rate that is equal to or greater than the surrendering provider's MA day-one admission rate or another MA day-one admission rate as may be agreed to by the Department.

(3) The change in the bed complements of the receiving and surrendering providers will maintain or improve access to medically necessary nursing facility services for MA recipients.

(4) Neither provider will receive an increase in reimbursement as a result of a change in its peer group if the bed transfer request is approved.

(5) If the proposed bed transfer will result in a change in peer group assignments under this chapter for the surrendering or receiving provider, the change will not have a negative effect on the MA Program, on MA recipients or on other facilities which are members of the affected peer group.

(6) Approval of the bed transfer request will not result in increased costs to the MA Program.

(7) None of the circumstances specified in § 1187.172(a)(4) applies.

(8) Both the surrendering provider and the receiving provider agree that the new or additional beds at the receiving provider shall be licensed, MA-certified and available for immediate occupancy before the surrendering provider decertifies and closes a bed.

(b) The Department may deny a bed transfer request even if the conditions specified in subsection (a) are satisfied if the Department determines one of the following:

(1) Approval of the request would negatively affect the Department's goal to rebalance the Commonwealth's publicly-funded long-term living system to create a fuller array of service options for MA recipients.

(2) There are alternatives to the transfer of beds, such as an increase in home and community-based services, that would be less costly, more efficient

or more appropriate in assuring that long-term living care and services will be provided under the MA Program in a manner consistent with applicable Federal and State law.

(c) Approval of a bed transfer request is not a determination that additional MA-certified beds are needed to maintain or improve MA recipients' access to medically necessary services in the primary service area or county in which the receiving provider is located.

Cross References

This section cited in 55 Pa. Code § 1187.172 (relating to contents and submission of bed requests).

§ 1187.176. Criteria for the approval of bed requests other than bed transfer requests.

(a) The Department may approve a bed request, other than a bed transfer request, only if the following are satisfied:

(1) The bed request contains the information required under § 1187.172(a) (relating to contents and submission of bed requests).

(2) The additional MA-certified nursing facility beds are needed in the primary service area or the county in which the subject facility is located to maintain or improve MA recipients' access to medically necessary nursing facility services based on any of the following:

(i) The existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located is insufficient to assure that MA recipients have access to medically necessary nursing facility services.

(ii) Systemic barriers prevent MA recipients from accessing the existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located.

(iii) The applicant is proposing to admit and serve MA recipients who require specialized medical services in the subject facility and MA recipients do not have access to the specialized medical services in the existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located.

(3) The legal entity agrees, in a form acceptable to the Department, to the following:

(i) The subject facility will admit and serve MA day-one recipients.

(ii) The subject facility will maintain an MA occupancy rate that equals or exceeds the average MA occupancy rate of MA nursing facilities in the county in which the subject facility is or will be located or, in the case of a subject facility that is proposing to offer specialized medical services, the MA occupancy rate as may be agreed to by the Department.

(iii) The construction and operation of the new or additional beds will be economically and financially feasible without the receipt of MA fixed prop-

erty capital component payments, and it is not entitled to MA capital component payments for fixed property related to the new or additional beds.

(4) None of the circumstances specified in § 1187.172(a)(4) applies.

(b) In determining whether a need for additional MA-certified beds exists under subsection (a), the following will apply:

(1) MA-certified bed capacity will be deemed sufficient if the average annual overall occupancy rates of providers in the primary service area and county in which the subject facility is or will be located is 95% or less, based on the most recent MA cost report data submitted by those providers.

(2) If the average annual overall occupancy rates of providers in the primary service area or county in which the subject facility is located exceeds 95%, based on the most recent MA cost report data submitted by those providers, the Department will consider the following information in assessing whether a need for additional MA-certified beds exits:

(i) The total number of MA-certified nursing facility beds in the primary service area.

(ii) The total number of licensed nursing facility beds in the primary service area.

(iii) The annual overall occupancy rates of providers in the primary service area based on the most recent MA cost report data submitted by those providers.

(iv) The annual actual bed days in the primary service area for the most recent 3-year period including the most recent cost report period, as submitted by nursing facility providers in the primary service area.

(3) No systemic barrier that prevents MA recipients from accessing MA-certified bed capacity will be deemed to exist if the average MA occupancy rate and the average MA day-one admission rate of providers in the primary service area and county in which the subject facility is or will be located are above the Statewide average rates or within one percentage point below the Statewide rates.

(c) The Department may deny a bed request even if the conditions specified in subsection (a) are satisfied if the Department determines one of the following:

(1) Approval of the request would negatively affect the Department's goal to rebalance the Commonwealth's publicly-funded long-term living system to create a fuller array of service options for MA recipients.

(2) There are alternatives to the bed request, such as an increase in home and community-based services, that would be less costly, more efficient or more appropriate in assuring that long-term living care and services will be provided under the MA Program in a manner consistent with applicable Federal and State law.

Cross References

This section cited in 55 Pa. Code § 1187.172 (relating to contents andn submission of bed requests).

§ 1187.177. Time lines for completion of approved projects.

(a) If the Department approves a bed request, the approved project shall be completed in sufficient time so that the beds may be licensed, certified and available for occupancy within 3 years from the date of the Department's decision, or by another date as may be agreed to by the Department.

(b) The provider will make documentation available upon the Department's written request at any time and for so long as the nursing facility is an MA provider, as may be necessary to demonstrate compliance with the terms of the approved exception request.

Appendix A

Resource Utilization Group Index Scores for Case-Mix Adjustment Nursing Facility Reimbursement System

The following chart is a listing by group of the RUG-III index scores that the Department will use to set each nursing facility's 5.01 resident care rate for the quarter beginning July 1, 2010, and ending September 30, 2010, as set forth in § 1187.96 (relating to price- and rate-setting computations). The table has one column that is the RUG-III nursing CMI scores and a second column that is the RUG-III PA normalized index scores.

RUG-III VERSION 5.01 INDEX SCORES

RUG-III Group	*RUG-III Nursing CMI*	*RUG-III PA Normalized Index*
RLA	1.14	1.13
RLB	1.36	1.35
RMA	1.25	1.24
RMB	1.38	1.37
RMC	2.09	2.07
RHA	1.06	1.05
RHB	1.31	1.30
RHC	1.50	1.49
RHD	1.93	1.91
RVA	0.82	0.81
RVB	1.18	1.17
RVC	1.79	1.77
SE1	1.78	1.76
SE2	2.65	2.62
SE3	3.97	3.93
SSA	1.28	1.27
SSB	1.47	1.46
SSC	1.61	1.59

RUG-III Group	*RUG-III Nursing CMI*	*RUG-III PA Normalized Index*
CA1	0.67	0.66
CA2	0.76	0.75
CB1	0.94	0.93
CB2	1.08	1.07
CC1	1.16	1.15
CC2	1.19	1.18
CD1	1.37	1.36
CD2	1.46	1.45
IA1	0.49	0.49
IA2	0.60	0.59
IB1	0.80	0.79
IB2	0.88	0.87
BA1	0.41	0.41
BA2	0.58	0.57
BB1	0.78	0.77
BB2	0.87	0.86
PA1	0.39	0.39
PA2	0.52	0.51
PB1	0.66	0.65
PB2	0.68	0.67
PC1	0.77	0.76
PC2	0.86	0.85
PD1	1.00	0.99
PD2	1.01	1.00
PE1	1.13	1.12
PE2	1.19	1.18

The following chart is a listing by group of the RUG-III index scores that the Department will use to set each nursing facility's 5.12 resident care rate for rate years 2010-2011, 2011-2012 and 2012-2013 and each nursing facility's resident care rate beginning with rate year 2013-2014, and thereafter, as set forth in § 1187.96. The table has one column that is the RUG-III nursing CMI scores and a second column that is the RUG-III PA normalized index scores.

RUG-III VERSION 5.12 INDEX SCORES

RUG-III 44 Grouper	*RUG-III Nursing Only CMIs*	*RUG-III PA Normalized Index*
RLA	0.87	0.82
RLB	1.22	1.15
RMA	1.06	1.00

RUG-III 44 Grouper	*RUG-III Nursing Only CMIs*	*RUG-III PA Normalized Index*
RMB	1.20	1.13
RMC	1.48	1.39
RHA	0.96	0.90
RHB	1.16	1.09
RHC	1.30	1.22
RVA	0.89	0.84
RVB	1.14	1.07
RVC	1.24	1.16
RUA	0.85	0.80
RUB	1.05	0.99
RUC	1.43	1.34
SE1	1.28	1.20
SE2	1.52	1.43
SE3	1.86	1.75
SSA	1.11	1.04
SSB	1.15	1.08
SSC	1.24	1.16
CA1	0.82	0.77
CA2	0.91	0.85
CB1	0.92	0.86
CB2	1.00	0.94
CC1	1.08	1.01
CC2	1.23	1.15
IA1	0.58	0.54
IA2	0.63	0.59
IB1	0.73	0.69
IB2	0.76	0.71
BA1	0.52	0.49
BA2	0.61	0.57
BB1	0.71	0.67
BB2	0.75	0.70
PA1	0.51	0.48
PA2	0.53	0.50
PB1	0.55	0.52
PB2	0.56	0.53
PC1	0.70	0.66
PC2	0.72	0.68

RUG-III 44 Grouper	*RUG-III Nursing Only CMIs*	*RUG-III PA Normalized Index*
PD1	0.73	0.69
PD2	0.78	0.73
PE1	0.84	0.79
PE2	0.86	0.81

Source

The provisions of this Appendix A amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630. Immediately preceding text appears at serial pages (287078) and (332499).

Appendix B
MEDIANS AND PRICES FOR 2018-2019

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
1	ABRAMSON RESIDENCE	6/30/2016	6/30/2015	6/30/2014
1	BRIGHTON REHABILITATION & WELLNESS CTR	12/31/2015		
1	BROOMALL REHAB AND NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
1	CARE PAVILION NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
1	IMMACULATE MARY CTR FOR REHAB & HLTHCARE	6/30/2016	6/30/2014	6/30/2013
1	PARKHOUSE REHABILITATION AND NURSING CTR	12/31/2015		
1	ST FRANCIS CENTER FOR REHAB & HEALTHCARE	6/30/2016	6/30/2014	6/30/2013
1	ST JOHN SPECIALTY CARE CENTER	6/30/2016	6/30/2015	6/30/2014
1	ST JOSEPH'S MANOR (DBA ENTITY OF HRHS)	6/30/2016	6/30/2015	6/30/2014
	PG1 Median	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
		$139.07	$52.26	$26.74
	PG1 Price	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
		$162.71	$58.53	$27.81

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
2	ASBURY HEALTH CENTER	12/31/2015	12/31/2014	12/31/2013
2	ATTLEBORO NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	BALA NURSING AND RETIREMENT CENTER	6/30/2016	6/30/2015	6/30/2014
2	BALDWIN HEALTH CENTER	6/30/2016	6/30/2015	6/30/2014
2	BAPTIST HOMES OF WESTERN PENNSYLVANIA	6/30/2016	6/30/2015	6/30/2014
2	BEAVER VALLEY HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	BRANDYWINE HALL	6/30/2016	6/30/2015	6/30/2014

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Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
2	BRIARLEAF NURSING AND CONVAL CENTER	6/30/2016	6/30/2015	6/30/2014
2	BRIDGEVILLE REHAB AND CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	BROOKSIDE HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	BROOMALL MANOR	12/31/2015	12/31/2014	12/31/2013
2	BROOMALL PRESBYTERIAN VILLAGE	12/31/2015	12/31/2014	12/31/2013
2	BRYN MAWR EXTENDED CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	BUCKINGHAM VALLEY NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	CARING HEART REHAB AND NURSING CENTER	6/30/2016	6/30/2015	6/30/2014
2	CARING HEIGHTS COMMUNITY CARE & REHAB	12/31/2015	12/31/2014	12/31/2013
2	CATHEDRAL VILLAGE	6/30/2016	6/30/2015	6/30/2014
2	CENTENNIAL HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	CHAPEL MANOR	6/30/2016	6/30/2015	6/30/2014
2	CHARLES M. MORRIS NURSING AND REHAB CTR	6/30/2016	6/30/2015	6/30/2014
2	CHELTENHAM NURSING AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	CHERRY TREE NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
2	CHESTNUT HILL LODGE HEALTH AND REHAB CTR	12/31/2015	12/31/2014	12/31/2013
2	CHESWICK REHAB & WELLNESS CTR LLC	12/31/2015	12/31/2014	12/31/2013
2	CLIVEDEN NSG & REHAB CTR	12/31/2015	12/31/2014	12/31/2013
2	CONCORDIA AT VILLA ST. JOSEPH	6/30/2016	6/30/2015	6/30/2014
2	CONCORDIA LUTHERAN HEALTH AND HUMAN CARE	6/30/2016	6/30/2015	6/30/2014
2	CRANBERRY PLACE	6/30/2016	6/30/2015	6/30/2014
2	CRESTVIEW CENTER	6/30/2016	6/30/2015	6/30/2014
2	DEER MEADOWS REHABILITATION CENTER	6/30/2016	6/30/2014	6/30/2013
2	ELKINS CREST HEALTH & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	FAIRVIEW CARE CENTER OF BETHLEHEM PIKE	6/30/2016	6/30/2015	6/30/2014
2	FORBES CENTER FOR REHAB & HEALTHCARE LLC	12/31/2015	12/31/2014	12/31/2013
2	GARDEN SPRING NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
2	GERMANTOWN HOME	6/30/2016	6/30/2015	6/30/2014
2	GLENDALE UPTOWN HOME	12/31/2015	12/31/2014	12/31/2013
2	GREEN MEADOWS NURSING & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	GREENERY CENTER FOR REHAB & NURSING	12/31/2015	12/31/2014	12/31/2013
2	GREENLEAF NURSING HOME AND CONVAL CENTER	6/30/2016	6/30/2015	6/30/2014
2	GREENSBURG CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	GWYNEDD HEALTHCARE & REHABILITATION CTR	6/30/2016	6/30/2015	6/30/2014
2	HARBORVIEW REHAB & C C AT DOYLESTOWN	12/31/2015	12/31/2014	12/31/2013
2	HARBORVIEW REHAB & CARE CTR AT LANSDALE	12/31/2015	12/31/2014	12/31/2013
2	HARMAR VILLAGE CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	HARSTON HALL	6/30/2016	6/30/2015	6/30/2014
2	HEMPFIELD MANOR	12/31/2015	12/31/2014	12/31/2013
2	HIGHLAND PARK CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	HILLCREST CENTER	6/30/2016	6/30/2015	6/30/2014
2	IVY HILL REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	LAFAYETTE-REDEEMER (DBA ENTITY OF HRHS)	6/30/2016	6/30/2015	6/30/2014
2	LANGHORNE GARDENS HEALTH & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	LGAR HEALTH AND REHABILITATION CENTER	12/31/2015	12/31/2014	12/31/2013
2	LIFEQUEST NURSING CENTER	6/30/2016	6/30/2015	6/30/2014
2	LITTLE FLOWER MANOR	6/30/2016	6/30/2015	6/30/2014
2	LOYALHANNA CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	LUTHER WOODS NURSING & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	MAJESTIC OAKS REHAB & NURSING CENTER	12/31/2015	6/30/2013	6/30/2012
2	MANATAWNY MANOR INC	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SERVICES-MONTGOMERY	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SERVICES-WALLINGFORD	6/30/2016	6/30/2015	6/30/2014
2	MANORCARE HEALTH SVCS-BETHEL PARK	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
2	MANORCARE HEALTH SVCS-GREEN TREE	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-HUNTINGDON VALLEY	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-KING OF PRUSSIA	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-MONROEVILLE	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-NORTH HILLS	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-OXFORD VALLEY	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-PETERS TOWNSHIP	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-PITTSBURGH	6/30/2016	6/30/2015	6/30/2014
2	MANORCARE HEALTH SVCS-POTTSTOWN	12/31/2016	12/31/2015	12/31/2014
2	MANORCARE HEALTH SVCS-SHADYSIDE	6/30/2016	6/30/2015	6/30/2014
2	MANORCARE HEALTH SVCS-WHITEHALL BOROUGH	12/31/2015	12/31/2014	12/31/2013
2	MANORCARE HEALTH SVCS-YEADON	12/31/2015	12/31/2014	12/31/2013
2	MAPLEWOOD NURSING AND REHABILITATION CTR	12/31/2015	12/31/2014	12/31/2013
2	MARIAN MANOR CORPORATION	6/30/2016	6/30/2015	6/30/2014
2	MASONIC VILLAGE AT SEWICKLEY	12/31/2015	12/31/2014	12/31/2013
2	MEADOWVIEW REHAB & NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
2	MONROEVILLE REHAB & WELLNESS CENTER	12/31/2015	12/31/2014	12/31/2013
2	MOUNT MACRINA MANOR NURSING HOME	6/30/2016	6/30/2015	6/30/2014
2	MOUNTAINVIEW SPECIALTY CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	MT. LEBANON REHAB AND WELLNESS CENTER	12/31/2015	12/31/2014	12/31/2013
2	MURRYSVILLE REHAB & WELLNESS CENTER	12/31/2015	12/31/2014	12/31/2013
2	OAKWOOD HEALTHCARE & REHABILITATION CTR	6/30/2016	6/30/2015	6/30/2014
2	OXFORD HEALTH CENTER	12/31/2015	12/31/2014	12/31/2013
2	PAPERMILL ROAD NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	PAUL'S RUN	12/31/2015	12/31/2014	12/31/2013
2	PEMBROOKE HEALTH AND REHAB CENTER	12/31/2015	12/31/2014	6/30/2013
2	PENN CENTER FOR REHABILITATION AND CARE	6/30/2016	6/30/2015	6/30/2014

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
2	PENNSBURG MANOR	6/30/2016	6/30/2015	6/30/2014
2	PHILADELPHIA PROTESTANT HOME	12/31/2015	12/31/2014	12/31/2013
2	PHOEBE RICHLAND HCC	6/30/2016	6/30/2015	6/30/2014
2	POWERBACK REHABILITATION 1526	6/30/2016	6/30/2015	6/30/2014
2	PROSPECT PARK HEALTH AND REHAB CENTER	12/31/2015	12/31/2014	6/30/2013
2	PROVIDENCE CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	PROVIDENCE REHAB & HCC MERCY FITZGERALD	6/30/2016	6/30/2015	6/30/2014
2	QUAKERTOWN CENTER	6/30/2016	6/30/2015	6/30/2014
2	QUALITY LIFE SERVICES-APOLLO	6/30/2016	6/30/2015	6/30/2014
2	REGINA COMMUNITY NURSING CENTER	6/30/2016	6/30/2015	6/30/2014
2	REHAB & NURSING CTR GREATER PITTSBURGH	12/31/2015	12/31/2014	12/31/2013
2	RENAISSANCE HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	RIVER'S EDGE NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	RIVERSIDE CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	ROCHESTER MANOR	12/31/2015	12/31/2014	12/31/2013
2	SAINT ANNE HOME	6/30/2016	6/30/2015	6/30/2014
2	SANATOGA CENTER	6/30/2016	6/30/2015	6/30/2014
2	SAUNDERS HOUSE	6/30/2016	6/30/2015	6/30/2014
2	SENECA PLACE	6/30/2016	6/30/2015	6/30/2014
2	SILVER LAKE CENTER	6/30/2016	6/30/2015	6/30/2014
2	SILVER STREAM NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	SIMPSON HOUSE, INC	12/31/2015	12/31/2014	12/31/2013
2	SOMERTON NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	SOUTHMONT OF PRESBYTERIAN SENIORCARE	12/31/2016	12/31/2015	12/31/2014
2	SQUIRREL HILL CTR FOR REHAB AND HEALING	12/31/2015	12/31/2013	12/31/2012
2	ST JOHN NEUMANN CTR FOR REHAB & HLTHCARE	6/30/2016	6/30/2014	6/30/2013
2	ST MARTHA CENTER FOR REHAB & HEALTHCARE	6/30/2016	6/30/2014	6/30/2013

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Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
2	ST MARY CENTER FOR REHAB & HEALTHCARE	6/30/2016	6/30/2014	6/30/2013
2	ST MONICA CENTER FOR REHAB & HEALTHCARE	6/30/2016	6/30/2014	6/30/2013
2	ST. BARNABAS NURSING HOME	12/31/2015	12/31/2014	12/31/2013
2	ST. IGNATIUS NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	STERLING HEALTH CARE AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	SUBURBAN WOODS HEALTH AND REHAB CENTER	6/30/2016	12/31/2014	12/31/2013
2	SUNNYVIEW NURSING AND REHABILITATION CTR	12/31/2015		
2	TEL HAI RETIREMENT COMMUNITY	6/30/2016	6/30/2015	6/30/2014
2	THE BELVEDERE CENTER, GENESIS HEALTHCARE	6/30/2016	6/30/2015	6/30/2014
2	THE GROVE AT IRWIN	12/31/2015	12/31/2014	12/31/2013
2	THE PHOENIX CENTER FOR REHAB AND NURSING	12/31/2015	12/31/2014	12/31/2013
2	TOWNE MANOR EAST	12/31/2015	12/31/2014	12/31/2013
2	TRANSITIONS HEALTHCARE NORTH HUNTINGDON	12/31/2015	6/30/2014	6/30/2013
2	TRANSITIONS HEALTHCARE WASHINGTON PA	12/31/2015	6/30/2014	6/30/2013
2	TUCKER HOUSE NSG & REHAB CTR	12/31/2015	12/31/2014	12/31/2013
2	TWIN PINES HEALTH CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	UNIONTOWN HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
2	UPMC HERITAGE PLACE	6/30/2016	6/30/2015	6/30/2014
2	VALLEY MANOR REHAB AND HEALTHCARE CTR	6/30/2016	6/30/2015	6/30/2014
2	VILLAGE AT PENNWOOD	6/30/2016	6/30/2015	6/30/2014
2	VINCENTIAN HOME	6/30/2016	6/30/2015	6/30/2014
2	WESLEY ENHANCED LIVING AT STAPELEY	6/30/2016	6/30/2015	6/30/2014
2	WESLEY ENHANCED LIVING PENNYPACK PARK	12/31/2015	12/31/2014	12/31/2013
2	WEST HILLS HEALTH AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
2	WEXFORD HEALTHCARE CENTER	6/30/2016	6/30/2015	6/30/2014
2	WILLIAM PENN CARE CENTER	12/31/2015	12/31/2014	12/31/2013
2	WILLOW TERRACE	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
2	WILLOWS OF PRESBYTERIAN SENIORCARE, THE	12/31/2016	$46.84	12/31/2015	$26.29	12/31/2014
2	WOODHAVEN CARE CENTER	12/31/2015		12/31/2014		12/31/2013
2	YORK NURSING AND REHABILITATION CENTER	12/31/2015		12/31/2014		12/31/2013
PG2 Median	*Resident Care 5.12*		*Other Resident Rltd*		*Administrative*	
	$139.92		$52.46		$27.34	
PG2 Price	*Resident Care 5.12*		*Other Resident Rltd*		*Administrative*	
	$163.71					
Median Peer Group	Current Provider Name	Most Recent Cost Report End Date		Second Most Recent Cost Report End Date		Third Most Recent Cost Report End Date
3	AMBLER EXTENDED CARE CENTER	12/31/2015		12/31/2014		12/31/2013
3	ANN'S CHOICE	12/31/2015				
3	ARTMAN LUTHERAN HOME	6/30/2016		6/30/2015		6/30/2014
3	BARCLAY FRIENDS	12/31/2015		12/31/2014		12/31/2013
3	BEAVER HEALTHCARE AND REHABILITATION CTR	12/31/2015		12/31/2014		12/31/2013
3	BELAIR HEALTHCARE AND REHABILITATION CTR	6/30/2016		6/30/2014		6/30/2013
3	BELLE HAVEN HEALTHCARE & REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
3	BETHLEN HM OF THE HUNGARIAN RFRMD FED	12/31/2015		12/31/2014		12/31/2013
3	BRINTON MANOR NURSING & REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
3	CANTERBURY PLACE	12/31/2015		12/31/2014		12/31/2013
3	CHANDLER HALL HEALTH SERVICES INC	12/31/2015		12/31/2014		12/31/2013
3	CHRIST'S HOME RETIREMENT COMMUNITY	6/30/2016		6/30/2015		6/30/2014
3	CONCORDIA AT THE CEDARS	12/31/2015		12/31/2014		12/31/2013
3	CONNER-WILLIAMS NURSING HOME	6/30/2016		6/30/2015		6/30/2014

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
3	DOCK TERRACE	6/30/2016	6/30/2015	6/30/2014
3	DRESHER HILL HEALTH & REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
3	EDGEHILL NURSING AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	ELDERCREST HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
3	ELM TERRACE GARDENS	6/30/2016	6/30/2015	6/30/2014
3	FREDERICK LIVING-CEDARWOOD	12/31/2015	12/31/2014	12/31/2013
3	FRIENDSHIP VILLAGE OF SOUTH HILLS	12/31/2015	12/31/2014	12/31/2013
3	HARMON HOUSE CARE CENTER	12/31/2015	12/31/2014	12/31/2013
3	HAVENCREST HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
3	HICKORY HOUSE NURSING HOME	12/31/2015	12/31/2014	12/31/2013
3	HOLY FAMILY HOME	12/31/2015	12/31/2014	12/31/2013
3	HOPKINS CENTER	6/30/2016	6/30/2015	6/30/2014
3	JEFFERSON HILLS HEALTHCARE & REHAB CTR	12/31/2015	12/31/2014	12/31/2013
3	KEARSLEY REHAB AND NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
3	LAFAYETTE MANOR, INC	12/31/2015	12/31/2014	12/31/2013
3	LAUREL RIDGE CENTER	6/30/2016	6/30/2015	6/30/2014
3	LAUREL SQUARE HEALTHCARE & REHAB CTR	6/30/2016	6/30/2015	6/30/2014
3	LAWSON NURSING HOME, INC.	12/31/2015	12/31/2014	12/31/2013
3	LIBERTY CENTER FOR REHAB AND NURSING	12/31/2015	12/31/2014	12/31/2013
3	LITTLE SISTERS OF THE POOR	12/31/2015	12/31/2014	12/31/2013
3	LUTHERAN COMMUNITY AT TELFORD	6/30/2016	6/30/2015	6/30/2014
3	MANORCARE HEALTH SERVICES-NORTHSIDE	6/30/2016	6/30/2015	6/30/2014
3	MASONIC VILLAGE AT LAFAYETTE HILL	12/31/2015	12/31/2014	12/31/2013
3	MASONIC VILLAGE AT WARMINSTER	12/31/2015	12/31/2014	12/31/2013
3	MCMURRAY HILLS MANOR	6/30/2016	6/30/2015	6/30/2014
3	MEADOWCREST HEALTHCARE AND REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
3	MON VALLEY CARE CENTER	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
3	NAAMANS CREEK COUNTRY MANOR	6/30/2016	6/30/2015	6/30/2014
3	NORRITON SQUARE NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	NORTH HILLS HEALTH AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	NORTH STRABANE REHAB & WELLNESS CTR LLC	12/31/2015	12/31/2014	12/31/2013
3	OAK HILL HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
3	OAKMONT CENTER FOR NURSING AND REHAB	12/31/2015	12/31/2013	12/31/2012
3	PASSAVANT RETIREMENT AND HEALTH CENTER	6/30/2016	6/30/2015	6/30/2014
3	PENNYPACK NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	PETER BECKER COMMUNITY	6/30/2016	6/30/2015	6/30/2014
3	PHOEBE WYNCOTE	6/30/2016	6/30/2015	6/30/2014
3	PICKERING MANOR HOME	6/30/2016	6/30/2015	6/30/2014
3	PINE RUN HEALTH CENTER	6/30/2016	6/30/2015	6/30/2014
3	PLATINUM RIDGE CTR FOR REHAB & HEALING	12/31/2015	12/31/2014	6/30/2013
3	POWERBACK REHABILITATION 3485	6/30/2016	6/30/2015	6/30/2014
3	QUALITY LIFE SERVICES-CHICORA	6/30/2016	6/30/2015	6/30/2014
3	QUALITY LIFE SERVICES-HENRY CLAY	6/30/2016	6/30/2015	6/30/2014
3	QUALITY LIFE SERVICES-MARKLEYSBURG	6/30/2016	6/30/2015	6/30/2014
3	QUALITY LIFE SERVICES-SARVER	6/30/2016	6/30/2015	6/30/2014
3	REDSTONE HIGHLANDS HEALTH CARE CENTER	6/30/2016	6/30/2015	6/30/2014
3	REFORMED PRESBYTERIAN HOME	12/31/2015	12/31/2014	12/31/2013
3	RICHBORO REHABILITATION & NURSING CENTER	6/30/2016	6/30/2015	6/30/2014
3	ROSEMONT CARE AND REHABILITATION CENTER	12/31/2015	12/31/2014	12/31/2013
3	RYDAL PARK OF PHILADELPHIA PRSBYTR HOMES	12/31/2015	12/31/2014	12/31/2013
3	SAINT JOSEPH VILLA	6/30/2016	6/30/2015	6/30/2014
3	SAXONY HEALTH CENTER	12/31/2015	12/31/2014	12/31/2013
3	SCOTTDALE HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
3	SHERWOOD OAKS	6/30/2016	6/30/2015	6/30/2014

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
3	SOUDERTON MENNONITE HOMES	6/30/2016	6/30/2015	6/30/2014
3	SOUTH HILLS REHAB & WELLNESS CENTER	12/31/2015	12/31/2014	12/31/2013
3	SOUTHWESTERN NURSING CARE CENTER	12/31/2016	12/31/2015	6/30/2013
3	SPRINGS AT THE WATERMARK, THE	12/31/2015	12/31/2014	12/31/2013
3	STATESMAN HEALTH & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	THE COMMUNITY AT ROCKHILL	6/30/2016	6/30/2015	6/30/2014
3	THE GARDENS AT POTTSTOWN	12/31/2015	12/31/2014	12/31/2013
3	THE GROVE AT HARMONY	12/31/2015	12/31/2014	12/31/2013
3	THE GROVE AT LATROBE	12/31/2015	12/31/2014	12/31/2012
3	THE GROVE AT WASHINGTON	12/31/2015	12/31/2014	12/31/2013
3	TOWNE MANOR WEST	12/31/2015	12/31/2014	12/31/2013
3	TOWNVIEW HEALTH AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
3	TRANSITIONS HEALTHCARE AUTUMN GROVE C C	6/30/2016	6/30/2015	6/30/2014
3	VALENCIA WOODS AT ST BARNABAS	12/31/2015	12/31/2014	12/31/2013
3	VINCENTIAN DE MARILLAC	6/30/2016	6/30/2015	6/30/2014
3	WAYNE CENTER	6/30/2016	6/30/2015	6/30/2014
3	WESLEY ENHANCED LIVING MAIN LINE REHAB	12/31/2015	12/31/2014	12/31/2013
3	WESLEY ENHANCED LIVING-DOYLESTOWN	12/31/2015	12/31/2014	12/31/2013
3	WESTGATE HILLS REHAB AND NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
3	WILLOWBROOKE CT SCC AT BRITTANY POINTE	12/31/2015	12/31/2014	12/31/2013
PG3 Median	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*	
		$50.72	$28.69	
PG3 Price	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*	
	$176.31	$56.81	$29.84	

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
	PG4 Median	Resident Care 5.12	$52.07		$26.48	
	PG4 Price	Resident Care 5.12	$58.32		$27.54	
4	ALLIED SERVICES SKILLED NURSING CENTER	6/30/2016		6/30/2015		6/30/2014
4	CAMBRIA CARE CENTER	12/31/2015		12/31/2014		12/31/2013
4	CEDAR HAVEN HEALTHCARE CENTER	12/31/2015				
4	COLONIAL MANOR NURSING HOME	12/31/2015		12/31/2014		12/31/2013
4	CONESTOGA VIEW	12/31/2015		12/31/2014		12/31/2013
4	CROSS KEYS VILLAGE-BRETHREN HM COMM, THE	6/30/2016		6/30/2015		6/30/2014
4	LACKAWANNA HEALTH AND REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
4	MASONIC VILLAGE AT ELIZABETHTOWN	12/31/2015		12/31/2014		12/31/2013
4	MOUNTAIN CITY NURSING AND REHAB CENTER	6/30/2016		12/31/2014		12/31/2013
4	MOUNTAIN VIEW, A NURSING AND REHAB CTR	12/31/2015		12/31/2014		12/31/2013
4	PHOEBE ALLENTOWN HEALTH CARE	6/30/2016		6/30/2015		6/30/2014
4	SPRING CREEK REHAB AND NURSING CENTER	12/31/2014		12/31/2013		12/31/2012
4	THE GARDENS AT WEST SHORE	12/31/2015		12/31/2014		12/31/2013
	PG4 Price	Resident Care 5.12	Other Resident Rltd	Second	Administrative	Third
Median Peer Group	Current Provider Name	Most Recent Cost Report End Date		Most Recent Cost Report End Date		Most Recent Cost Report End Date
5	BERKSHIRE CENTER	6/30/2016		6/30/2015		6/30/2014
5	BERWICK RETIREMENT VILLAGE NRSNG HOME II	6/30/2016		6/30/2015		6/30/2014
5	BIRCHWOOD NURSING AND REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
5	BLOOMSBURG CARE AND REHABILITATION CTR	6/30/2016		6/30/2015		6/30/2014
5	BRETHREN VILLAGE	6/30/2016		6/30/2015		6/30/2014

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Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
5	COLONIAL PARK CARE CENTER	12/31/2015	12/31/2014	12/31/2013
5	CORRY MANOR	12/31/2015	12/31/2014	12/31/2013
5	EDINBORO MANOR	12/31/2015	12/31/2014	12/31/2013
5	EPHRATA MANOR	12/31/2015	12/31/2014	12/31/2013
5	FAIRLANE GARDENS NSG & REHAB AT READING	12/31/2015	12/31/2014	12/31/2013
5	FAIRVIEW MANOR	12/31/2015	12/31/2014	12/31/2013
5	FELLOWSHIP MANOR	6/30/2016	6/30/2015	6/30/2014
5	FREY VILLAGE	12/31/2015	12/31/2014	12/31/2013
5	HANOVER HALL	12/31/2015	12/31/2014	12/31/2013
5	HARRISON SENIOR LIVING OF CHRISTIANA	12/31/2015	12/31/2014	12/31/2013
5	HIGHLAND MANOR REHAB & NURSING CENTER	12/31/2015	6/30/2013	6/30/2012
5	HOLY FAMILY MANOR	12/31/2015	12/31/2014	12/31/2013
5	HOMEWOOD AT PLUM CREEK	12/31/2015	12/31/2014	12/31/2013
5	JEWISH HOME OF EASTERN PENNSYLVANIA	12/31/2015	12/31/2014	12/31/2013
5	JEWISH HOME OF GREATER HARRISBURG	6/30/2016	6/30/2015	6/30/2014
5	KUTZTOWN MANOR	6/30/2016	6/30/2015	6/30/2014
5	LANCASHIRE HALL	12/31/2015	12/31/2014	12/31/2013
5	LAUREL CENTER	6/30/2016	6/30/2015	6/30/2014
5	LECOM AT PRESQUE ISLE, INC.	12/31/2015	12/31/2014	12/31/2013
5	LEHIGH CENTER	6/30/2016	6/30/2015	6/30/2014
5	LITTLE FLOWER MANOR OF DIOCESE SCRANTON	12/31/2015	12/31/2014	12/31/2013
5	LUTHERAN HOME AT TOPTON	12/31/2015	12/31/2014	12/31/2013
5	MAHONING VALLEY NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-ALLENTOWN	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-BETHLEHEM (2021)	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-BETHLEHEM (2029)	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-CAMP HILL	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
5	MANORCARE HEALTH SVCS-CARLISLE	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-DALLASTOWN	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-EASTON	12/31/2016	12/31/2015	12/31/2014
5	MANORCARE HEALTH SVCS-KINGSTON	12/31/2016	12/31/2015	12/31/2014
5	MANORCARE HEALTH SVCS-KINGSTON COURT	6/30/2016	6/30/2015	6/30/2014
5	MANORCARE HEALTH SVCS-LANCASTER	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-LAURELDALE	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-LEBANON	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-SINKING SPRING	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-WEST READING NORTH	12/31/2015	12/31/2014	12/31/2013
5	MANORCARE HEALTH SVCS-YORK NORTH	6/30/2016	6/30/2015	6/30/2014
5	MANORCARE HEALTH SVCS-YORK SOUTH	6/30/2016	6/30/2015	6/30/2014
5	MANORCARE HLTH SVCS & REHAB-WEST ALLEN	6/30/2016	6/30/2015	6/30/2014
5	MEADOWS NURSING AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
5	MENNONITE HOME, THE	6/30/2016	6/30/2015	6/30/2014
5	MESSIAH LIFEWAYS AT MESSIAH VILLAGE	6/30/2016	6/30/2015	6/30/2014
5	MIFFLIN CENTER	6/30/2016	6/30/2015	6/30/2014
5	MILLCREEK MANOR	6/30/2016	6/30/2015	6/30/2014
5	MORAVIAN MANOR	12/31/2015	12/31/2014	12/31/2013
5	MOUNTAIN VIEW CARE AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
5	OLD ORCHARD HEALTH CARE CENTER	12/31/2016	12/31/2015	12/31/2014
5	PHOEBE BERKS HEALTH CARE CENTER, INC	6/30/2016	6/30/2015	6/30/2014
5	PLEASANT VIEW RETIREMENT COMMUNITY	12/31/2015	12/31/2014	12/31/2013
5	PREMIER AT PERRY VLG FOR NURSE AND REHAB	12/31/2015	12/31/2014	12/31/2013
5	PREMIER AT SUSQUEHANNA FOR NURSE & REHAB	12/31/2015	12/31/2014	12/31/2013
5	QUARRYVILLE PRESBYTERIAN RETIREMENT COMM	6/30/2016	6/30/2015	6/30/2014
5	REST HAVEN-YORK	6/30/2016	6/30/2015	6/30/2014

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
5	RIVER RUN REHAB AND NURSING CENTER	12/31/2015		12/31/2014		12/31/2012
5	RIVERSIDE REHABILITATION AND NURSING CTR	12/31/2015		12/31/2014		12/31/2013
5	RIVERSTREET MANOR	6/30/2016		6/30/2015		6/30/2014
5	ROSE CITY NURSING AND REHAB AT LANCASTER	12/31/2015		12/31/2014		12/31/2013
5	SAINT MARY'S EAST	12/31/2015		12/31/2014		12/31/2013
5	SHIPPENSBURG HEALTH CARE CENTER	12/31/2015		12/31/2014		12/31/2013
5	SLATE BELT HEALTH AND REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
5	SPRUCE MANOR NURSING AND REHAB CENTER	6/30/2016		6/30/2014		6/30/2013
5	STONERIDGE TOWNE CENTRE	12/31/2015		12/31/2014		12/31/2013
5	SUSQUEHANNA VALLEY NURSING AND REHAB CTR	6/30/2016		12/31/2014		12/31/2013
5	THE GARDENS AT EAST MOUNTAIN	12/31/2015		12/31/2014		12/31/2013
5	THE GARDENS AT EASTON	12/31/2015		12/31/2014		12/31/2013
5	THE GARDENS AT ORANGEVILLE	12/31/2015		12/31/2014		12/31/2013
5	THE GARDENS AT SCRANTON	12/31/2015		12/31/2014		12/31/2013
5	THE GARDENS AT TUNKHANNOCK	12/31/2015		12/31/2014		12/31/2013
5	THE GARDENS AT WYOMING VALLEY	12/31/2015		12/31/2014		12/31/2013
5	THE PAVILION AT ST LUKE VILLAGE	12/31/2015		12/31/2014		12/31/2013
5	TIMBER RIDGE HEALTH CENTER	12/31/2015		12/31/2014		12/31/2013
5	TWINBROOK HEALTHCARE & REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
5	WEATHERWOOD HEALTHCARE AND REHAB CTR	12/31/2015		12/31/2014		12/31/2013
5	WESLEY VILLAGE	12/31/2015		12/31/2014		12/31/2013
5	WESTERN RESERVE HEALTHCARE & REHAB CTR	12/31/2015		12/31/2014		12/31/2013
	PG5 Median	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$132.67	$44.04		$24.64	
	PG5 Price	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$155.22	$49.32		$25.63	

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
6	ABINGTON CREST HEALTHCARE & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
6	ABINGTON MANOR	6/30/2016	6/30/2015	6/30/2014
6	BALL PAVILION, THE	6/30/2016	6/30/2015	6/30/2014
6	BELLE REVE HEALTH CARE CENTER	12/31/2015	12/31/2013	12/31/2012
6	BETHANY VILLAGE RETIREMENT CENTER	12/31/2015	12/31/2014	12/31/2013
6	BONHAM NURSING CENTER	12/31/2015	12/31/2014	12/31/2013
6	CALVARY FELLOWSHIP HOMES, INC	6/30/2016	6/30/2015	6/30/2014
6	CARBONDALE NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
6	CHAPEL POINTE AT CARLISLE	12/31/2015	12/31/2014	12/31/2013
6	CHURCH OF GOD HOME, INC	12/31/2015	12/31/2014	12/31/2013
6	CORNWALL MANOR	12/31/2015	12/31/2014	12/31/2013
6	COUNTRY MEADOWS NURSING CENTER-BETHLEHEM	12/31/2015	12/31/2014	12/31/2013
6	COUNTRYSIDE CHRISTIAN COMMUNITY	12/31/2015	12/31/2014	12/31/2013
6	COURTYARD GARDENS NURSING AND REHAB CTR	12/31/2015	12/31/2014	12/31/2013
6	CREEKSIDE HEALTH AND REHABILITATION CTR	12/31/2015	12/31/2014	12/31/2013
6	CUMBERLAND CROSSINGS RETIREMENT COMM	12/31/2015	12/31/2014	12/31/2013
6	DUNMORE HEALTH CARE CENTER	12/31/2015	12/31/2014	12/31/2013
6	ELIZABETH MANOR HEALTHCARE & REHAB CTR	12/31/2015	12/31/2014	12/31/2013
6	ELIZABETHTOWN HEALTHCARE & REHAB CENTER	6/30/2016	12/31/2014	12/31/2013
6	ELMWOOD GARDENS OF PRESBY SENIOR CARE	12/31/2015	12/31/2014	12/31/2013
6	FAIRMOUNT HOMES	6/30/2016	6/30/2015	6/30/2014
6	FOREST PARK HEALTH CENTER	12/31/2015	12/31/2014	12/31/2013
6	FORESTVIEW	12/31/2015	12/31/2014	12/31/2013
6	GARDEN SPOT VILLAGE	6/30/2016	6/30/2015	6/30/2014
6	GREEN RIDGE CARE CENTER	12/31/2015	12/31/2014	12/31/2013
6	GUARDIAN HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
6	HAMILTON ARMS CENTER	6/30/2016	6/30/2015	6/30/2014

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Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
6	HAMPTON HOUSE	6/30/2016	6/30/2015	6/30/2014
6	HOLY FAMILY RESIDENCE	12/31/2015	12/31/2014	12/31/2013
6	HOMELAND CENTER	6/30/2016	6/30/2015	6/30/2014
6	HOMESTEAD VILLAGE, INC	6/30/2016	6/30/2015	6/30/2014
6	KINGSTON HEALTH CARE CENTER	12/31/2015	12/31/2012	12/31/2011
6	KINKORA PYTHIAN HOME CORPORATION	6/30/2016	6/30/2015	6/30/2014
6	LANDIS HOMES	6/30/2016	6/30/2015	6/30/2014
6	LEBANON VALLEY BRETHREN HOME	12/31/2015	12/31/2014	12/31/2013
6	LEBANON VALLEY HOME THE	12/31/2015	12/31/2014	12/31/2013
6	LINWOOD NURSING AND REHABILITATION CTR	6/30/2016	6/30/2015	6/30/2014
6	LUTHER ACRES MANOR	12/31/2015	12/31/2014	12/31/2013
6	LUTHER CREST NURSING FACILITY	12/31/2015	12/31/2014	12/31/2013
6	MANCHESTER COMMONS OF PRESBY SR. CARE	12/31/2015	12/31/2014	12/31/2013
6	MAPLE FARM	6/30/2016	6/30/2015	6/30/2014
6	MERCY CENTER NURSING UNIT, INC	12/31/2015	12/31/2014	12/31/2013
6	MID VALLEY HEALTH CARE CENTER	12/31/2015	12/31/2012	12/31/2011
6	MILFORD HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
6	MISERICORDIA NURSING & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
6	MORAVIAN HALL SQ, HLTH AND WELLNESS CTR	6/30/2016	6/30/2015	6/30/2014
6	MOSSER NURSING HOME	6/30/2016	6/30/2015	6/30/2014
6	MOUNT HOPE NAZARENE RETIREMENT COMMUNITY	6/30/2016	6/30/2015	6/30/2014
6	MOUNTAIN TOP HEALTHCARE AND REHAB CTR	12/31/2015	12/31/2014	12/31/2013
6	NEW EASTWOOD HEALTHCARE AND REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
6	NORMANDIE RIDGE	12/31/2015	12/31/2014	12/31/2013
6	SAINT ANNE'S RETIREMENT COMMUNITY	6/30/2016	6/30/2015	6/30/2014
6	SAINT MARY'S AT ASBURY RIDGE	12/31/2015	12/31/2014	12/31/2013
6	SAINT MARY'S VILLA NURSING HOME, INC	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
6	SARAH A TODD MEMORIAL HOME	12/31/2015	12/31/2014	12/31/2013
6	SARAH REED SENIOR LIVING	6/30/2016	6/30/2015	6/30/2014
6	SCRANTON HEALTH CARE CENTER	12/31/2015	12/31/2014	12/31/2013
6	SMITH HEALTH CARE, LTD	6/30/2016	6/30/2015	6/30/2014
6	SPANG CREST MANOR	12/31/2015	12/31/2014	12/31/2013
6	SPIRITRUST LUTHERAN VLG AT SHREWSBURY	12/31/2015	12/31/2014	12/31/2013
6	SPIRITRUST LUTHERAN VLG AT SPRENKLE DRIVE	12/31/2015	12/31/2014	12/31/2013
6	SPIRITRUST LUTHERAN VLG AT UTZ TERRACE	12/31/2015	12/31/2014	12/31/2013
6	ST. LUKE'S VILLA	6/30/2016	6/30/2015	6/30/2014
6	STONEBRIDGE HEALTH & REHAB CENTER, LLC	6/30/2016	12/31/2014	12/31/2013
6	STONERIDGE POPLAR RUN	12/31/2015	12/31/2014	12/31/2013
6	SUNSET RIDGE HEALTHCARE & REHAB CENTER	12/31/2014	12/31/2013	12/31/2012
6	SWAIM HEALTH CENTER	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT BLUE RIDGE	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT BUTLER	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT CAMP HILL	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT CAMPBELLTOWN	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT LAKESIDE	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT LITITZ	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT MILLVILLE	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT PALMYRA	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS AT STEVENS	12/31/2015	12/31/2014	12/31/2013
6	THE GARDENS FOR MEMORY CARE AT EASTON	12/31/2015	12/31/2014	12/31/2013
6	THE MANOR AT ST LUKE VILLAGE	12/31/2015	12/31/2014	12/31/2013
6	THORNWALD HOME	12/31/2015	12/31/2014	12/31/2013
6	UNITED ZION RETIREMENT COMMUNITY	12/31/2015	12/31/2014	12/31/2013
6	VILLAGE AT LUTHER SQUARE	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
6	WALNUT CREEK HEALTHCARE & REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
6	WESTMINSTER VILLAGE	12/31/2015		12/31/2014		12/31/2013
6	WESTON REHABILITATION AND NURSING CENTER	12/31/2015		12/31/2014		6/30/2012
6	WYOMISSING HEALTH AND REHABILITATION CTR	6/30/2015		12/31/2013		12/31/2012
6	ZERBE SISTERS NURSING CENTER, INC.	6/30/2016		6/30/2015		6/30/2014
	PG6 Median	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$150.61	$50.74		$29.13	
	PG6 Price	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$176.21	$56.83		$30.30	
Median Peer Group	Current Provider Name	Most Recent Cost Report End Date		Second Most Recent Cost Report End Date		Third Most Recent Cost Report End Date
8	ALTOONA CENTER FOR NURSING CARE	12/31/2015		12/31/2014		12/31/2013
8	ARBUTUS PARK MANOR	6/30/2016		6/30/2015		6/30/2014
8	CENTRE CREST	12/31/2016		12/31/2015		12/31/2014
8	GARVEY MANOR	12/31/2015		12/31/2014		12/31/2013
8	HEARTHSIDE REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
8	HILLVIEW HEALTHCARE AND REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
8	HOMEWOOD AT MARTINSBURG PA INC	12/31/2015		12/31/2014		12/31/2013
8	LAUREL WOOD CARE CENTER	12/31/2015		12/31/2014		12/31/2013
8	LOYALSOCK REHAB CENTER	6/30/2016		12/31/2013		12/31/2012
8	MANORCARE HEALTH SVCS-JERSEY SHORE	12/31/2015		12/31/2014		12/31/2013
8	MANORCARE HEALTH SVCS-WILLIAMSPORT NORTH	12/31/2015		12/31/2014		12/31/2013
8	MAYBROOK HILLS REHAB & HEALTHCARE CENTER	12/31/2015		12/31/2014		

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
	PG8 Median	*Resident Care 5.12*	$49.36		$23.58	
	PG8 Price	*Resident Care 5.12*	$55.28		$24.52	
Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*		*Second Most Recent Cost Report End Date*		*Third Most Recent Cost Report End Date*
8	MEADOW VIEW NURSING CENTER	6/30/2016		6/30/2015		6/30/2014
8	MORRISONS COVE HOME	12/31/2015		12/31/2014		12/31/2013
8	ORCHARD MANOR, INC	6/30/2016		6/30/2015		6/30/2014
8	ROSE VIEW NURSING & REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
8	SAINT PAUL HOMES	12/31/2015		12/31/2014		12/31/2013
8	SIEMONS' LAKEVIEW MANOR NSG AND REHAB	12/31/2015		12/31/2014		12/31/2013
8	THE GROVE AT GREENVILLE	12/31/2015		12/31/2014		12/31/2013
8	VALLEY VIEW NURSING CENTER	12/31/2015		12/31/2014		12/31/2013
8	WILLIAMSPORT HOME, THE	12/31/2015		12/31/2014		12/31/2013
8	WINDBER WOODS SENIOR LIVING & REHAB CTR	6/30/2016		6/30/2015		6/30/2014
8	WINDY HILL VILLAGE OF PRESBYTERIAN HOMES	12/31/2015		12/31/2014		12/31/2013
9	AVALON SPRINGS NURSING CENTER	12/31/2015		12/31/2014		12/31/2013
9	CLEPPER MANOR	12/31/2015		12/31/2014		12/31/2013
9	EPWORTH HEALTHCARE AND REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
9	GROVE MANOR	6/30/2016		6/30/2015		6/30/2014
9	HAIDA HEALTHCARE AND REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
9	HOSPITALITY CARE CENTER OF HERMITAGE INC	12/31/2015		12/31/2014		12/31/2013

Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Other Resident Rltd	Second Most Recent Cost Report End Date	Administrative	Third Most Recent Cost Report End Date
	PG9 Median		$44.95		$23.12	
9	LAUREL VIEW VILLAGE	6/30/2016		6/30/2015		6/30/2014
9	LUTHERAN HOME AT HOLLIDAYSBURG, THE	12/31/2015		12/31/2014		12/31/2013
9	LUTHERAN HOME AT JOHNSTOWN, THE	12/31/2015		12/31/2014		12/31/2013
9	MANORCARE HEALTH SVCS-WILLIAMSPORT SOUTH	12/31/2015		12/31/2014		12/31/2013
9	MAPLE WINDS HEALTHCARE & REHAB CTR, LLC	12/31/2015		12/31/2014		12/31/2013
9	MEYERSDALE HEALTHCARE AND REHAB CTR	12/31/2015		12/31/2014		12/31/2013
9	NUGENT CONVALESCENT HOME	12/31/2015		12/31/2014		12/31/2013
9	PRESBYTERIAN HOMES-PRESBYTERY-HUNTINGDON	12/31/2015		12/31/2014		12/31/2013
9	QUALITY LIFE SERVICES-GROVE CITY	6/30/2016		6/30/2015		6/30/2014
9	QUALITY LIFE SERVICES-MERCER	6/30/2016		6/30/2015		6/30/2014
9	QUALITY LIFE SERVICES-WESTMONT	12/31/2014		12/31/2013		12/31/2012
9	RICHLAND HEALTHCARE AND REHAB CENTER	12/31/2015		12/31/2014		12/31/2013
9	SAINT JOHN XXIII HOME	12/31/2015		12/31/2014		12/31/2013
9	THE PATRIOT, A CHOICE COMMUNITY	12/31/2015		12/31/2014		12/31/2013
	PG9 Median	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$118.86	$50.34		$24.04	
	PG9 Price	*Resident Care 5.12*	*Other Resident Rltd*		*Administrative*	
		$139.07				
Median Peer Group	Current Provider Name	Most Recent Cost Report End Date		Second Most Recent Cost Report End Date		Third Most Recent Cost Report End Date
11	BROAD ACRES HEALTH AND REHAB CENTER	12/31/2016		12/31/2015		12/31/2014
11	BROAD MOUNTAIN HEALTH & REHAB CENTER	6/30/2016		6/30/2015		6/30/2014
11	BROOKVIEW HEALTH CARE CENTER	12/31/2015		12/31/2014		12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
11	CHRIST THE KING MANOR	6/30/2016	6/30/2015	6/30/2014
11	CLARVIEW NURSING AND REHAB CENTER	12/31/2016	12/31/2015	12/31/2014
11	DUBOIS NURSING HOME	6/30/2016	6/30/2015	6/30/2014
11	ELK HAVEN NURSING HOME	6/30/2016	6/30/2015	6/30/2014
11	ELLEN MEMORIAL HEALTH CARE CENTER	6/30/2016	6/30/2015	6/30/2014
11	FALLING SPRING NURSING AND REHAB CENTER	6/30/2016	6/30/2015	
11	FOREST CITY NURSING AND REHAB CENTER	12/31/2016	12/31/2015	12/31/2014
11	GRANDVIEW NURSING AND REHABILITATION	6/30/2016	6/30/2015	6/30/2014
11	GREEN HOME, INC, THE	6/30/2016	6/30/2015	6/30/2014
11	HIGHLANDS HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
11	HOMETOWN NURSING AND REHAB CENTER	12/31/2016	12/31/2015	12/31/2014
11	JEFFERSON MANOR HEALTH CENTER	6/30/2016	6/30/2015	6/30/2014
11	JULIA POUND CARE CENTER	12/31/2015	12/31/2014	12/31/2013
11	JULIA RIBAUDO EXTENDED CARE CENTER	12/31/2015	12/31/2014	12/31/2013
11	KITTANNING CARE CENTER	12/31/2015	12/31/2014	12/31/2013
11	MANORCARE HEALTH SVCS-CHAMBERSBURG	12/31/2015	12/31/2014	12/31/2013
11	MANORCARE HEALTH SVCS-POTTSVILLE	12/31/2016	12/31/2015	12/31/2014
11	MANORCARE HEALTH SVCS-SUNBURY	12/31/2016	12/31/2015	12/31/2014
11	MILTON REHABILITATION AND NURSING CENTER	12/31/2015	12/31/2014	6/30/2011
11	MOUNT CARMEL NURSING AND REHAB CENTER	12/31/2016	12/31/2015	12/31/2014
11	MOUNTAIN LAUREL HEALTHCARE & REHAB CTR	6/30/2016	6/30/2014	6/30/2013
11	NOTTINGHAM VILLAGE	12/31/2015	12/31/2014	12/31/2013
11	OHESSON MANOR	12/31/2015	12/31/2014	12/31/2013
11	ORWIGSBURG NURSING & REHAB CENTER	6/30/2016	6/30/2015	6/30/2014
11	PARK AVENUE REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
11	PENNKNOLL VILLAGE	12/31/2015	12/31/2014	12/31/2013
11	QUALITY LIFE SERVICES-NEW CASTLE	6/30/2016	6/30/2015	6/30/2013

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Median Peer Group	Current Provider Name	Most Recent Cost Report End Date	Second Most Recent Cost Report End Date	Third Most Recent Cost Report End Date
11	QUINCY RETIREMENT COMMUNITY	12/31/2015	12/31/2014	12/31/2013
11	RIDGEVIEW HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
11	RIVERWOODS	12/31/2015	12/31/2014	12/31/2013
11	ROLLING FIELDS, INC	12/31/2015	12/31/2014	12/31/2013
11	ROLLING MEADOWS	6/30/2016	6/30/2015	6/30/2014
11	SCHUYLKILL CENTER	6/30/2016	6/30/2015	6/30/2014
11	SENA-KEAN MANOR	12/31/2015	12/31/2014	12/31/2013
11	SETON MANOR NURSING & REHABILITATION CTR	6/30/2016	6/30/2015	6/30/2014
11	SHENANDOAH MANOR NURSING CENTER	12/31/2016	12/31/2015	12/31/2014
11	SHIPPENVILLE HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
11	SUGAR CREEK STATION SKILLED NSG & REHAB	12/31/2015	12/31/2014	12/31/2013
11	SWEDEN VALLEY MANOR	12/31/2015	12/31/2014	12/31/2013
11	THE GARDENS AT STROUD	12/31/2015	12/31/2014	12/31/2013
11	THE MANOR AT PENN VILLAGE	12/31/2015	12/31/2014	12/31/2013
11	TRANSITIONS HEALTHCARE GETTYSBURG	12/31/2015	12/31/2014	12/31/2013
11	TREMONT HEALTH & REHABILITATION CENTER	6/30/2016	6/30/2015	6/30/2014
11	VALLEY VIEW HAVEN, INC	12/31/2015	12/31/2014	12/31/2013
11	WARREN MANOR	12/31/2015	12/31/2014	12/31/2013
11	WATSONTOWN REHABILITATION AND NRSG CTR	12/31/2015	12/31/2014	12/31/2011
11	WAYNE WOODLANDS MANOR	6/30/2016	6/30/2015	6/30/2014
11	WESBURY UNITED METHODIST COMMUNITY	12/31/2015	12/31/2014	12/31/2013
11	WILLIAM PENN HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
11	WOODLAND PARK REHAB CENTER	6/30/2016	12/31/2014	12/31/2013
PG11 Median	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*	
	$123.48	$43.04	$22.28	
PG11 Price	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*	
	$144.47	$48.20	$23.17	

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Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
12	ATHENS HEALTH AND REHABILITATION CENTER	6/30/2016		
12	AVALON NURSING CENTER	6/30/2016	6/30/2015	6/30/2014
12	BEACON RIDGE, A CHOICE COMMUNITY	12/31/2015	12/31/2014	12/31/2013
12	BRADFORD ECUMENICAL HOME, INC	12/31/2015	12/31/2014	12/31/2013
12	BRADFORD MANOR	12/31/2015	12/31/2014	12/31/2013
12	BROOKLINE MANOR AND REHABILITATIVE SRVCS	12/31/2015	12/31/2014	12/31/2013
12	BROOKMONT HEALTHCARE CENTER LLC	12/31/2015	12/31/2014	12/31/2013
12	BUFFALO VALLEY LUTHERAN VILLAGE	12/31/2015	12/31/2014	12/31/2013
12	CARING PLACE, THE	6/30/2016	6/30/2015	6/30/2014
12	CARLETON HEALTHCARE & REHABILITATION CTR	12/31/2015	12/31/2014	12/31/2013
12	CHAMBERS POINTE HEALTH CARE CENTER	12/31/2015	12/31/2014	12/31/2013
12	CLARION HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	DARWAY HEALTHCARE & REHABILITATION CTR	12/31/2015	12/31/2014	12/31/2013
12	DONAHOE MANOR	6/30/2016	6/30/2015	6/30/2014
12	DR ARTHUR CLIFTON MCKINLEY HEALTH CENTER	6/30/2016	6/30/2015	6/30/2014
12	EDISON MANOR NURSING AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	EMMANUEL CENTER FOR NURSING AND REHAB	12/31/2015	12/31/2014	12/31/2013
12	GETTYSBURG CENTER	6/30/2016	6/30/2015	6/30/2014
12	GREEN VALLEY SKILLED NSG & REHAB CENTER	6/30/2014	6/30/2013	6/30/2012
12	GUY AND MARY FELT MANOR, INC	6/30/2016	6/30/2015	6/30/2014
12	HAVEN CONVALESCENT HOME, INC	12/31/2015	12/31/2014	12/31/2013
12	HIGHLAND VIEW HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	HILLSDALE PARK REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	HUNTINGDON PARK REHAB CENTER	6/30/2016	6/30/2014	6/30/2013
12	JAMESON CARE CENTER	12/31/2015	12/31/2014	12/31/2013
12	KINZUA HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	LAKEVIEW HEALTHCARE & REHABILITATION CTR	12/31/2015	12/31/2014	12/31/2013

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
12	LOCUST GROVE RETIREMENT VILLAGE	12/31/2015	12/31/2014	12/31/2013
12	LUTHERAN HOME AT KANE, THE	12/31/2015	12/31/2014	12/31/2013
12	MEADOW VIEW HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	MULBERRY HEALTHCARE & REHAB CTR	12/31/2015	12/31/2014	12/31/2013
12	NURSING & REHABILITATION AT THE MANSION	12/31/2015	12/31/2014	12/31/2013
12	OAKWOOD HEIGHTS OF PRESBY SENIOR CARE	12/31/2015	12/31/2014	12/31/2013
12	OIL CITY HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	PARAMOUNT NURSING & REHAB AT FAYETTEVILLE	12/31/2015	12/31/2014	12/31/2013
12	QUALITY LIFE SERVICES-SUGAR CREEK	6/30/2016	6/30/2015	6/30/2014
12	RICHFIELD HEALTHCARE AND REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	RIDGEVIEW HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	ROLLING HILLS HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	SAYRE HEALTH CARE CENTER, LLC	6/30/2016	6/30/2015	6/30/2014
12	SCENERY HILL HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	SHENANGO PRESBYTERIAN SENIORCARE	12/31/2015	12/31/2014	12/31/2013
12	SHOOK HOME, THE	12/31/2015	12/31/2014	12/31/2013
12	SNYDER MEMORIAL HEALTH CARE CENTER	12/31/2015	12/31/2014	12/31/2013
12	SPIRITRUST LUTHERAN VLG AT GETTYSBURG	12/31/2015	12/31/2014	12/31/2013
12	THE GARDENS AT GETTYSBURG	12/31/2015	12/31/2014	12/31/2013
12	THE GARDENS AT YORK TERRACE	12/31/2015	12/31/2014	12/31/2013
12	THE GROVE AT NEW CASTLE	12/31/2015	12/31/2014	12/31/2013
12	THE GROVE AT NEW WILMINGTON	12/31/2015	12/31/2014	12/31/2013
12	THE PAVILION AT BRMC	6/30/2016	6/30/2015	6/30/2014
12	TITUSVILLE HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	WAYNESBURG HEALTHCARE & REHAB CENTER	12/31/2015	12/31/2014	12/31/2013
12	WESTMINSTER WOODS AT HUNTINGDON	12/31/2015	12/31/2014	12/31/2013
12	WHITESTONE CARE CENTER	12/31/2015	12/31/2014	12/31/2013

G12 Median	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
	$119.20	$42.33	$22.66

PG12 Price	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
	$139.46	$47.41	$23.57

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
13	ARISTACARE AT MEADOW SPRINGS	6/30/2016	6/30/2015	6/30/2014
13	FOX SUBACUTE AT CLARA BURKE	12/31/2015	12/31/2014	12/31/2013
13	FOX SUBACUTE AT MECHANICSBURG	6/30/2016	6/30/2015	6/30/2014
13	FOX SUBACUTE CENTER	12/31/2015	12/31/2014	12/31/2013
13	GOOD SHEPHERD HOME RAKER CENTER	6/30/2016	6/30/2015	6/30/2014
13	GOOD SHEPHERD HOME-BETHLEHEM	6/30/2016	6/30/2015	6/30/2014
13	INGLIS HOUSE	6/30/2016	6/30/2015	6/30/2014
13	MARGARET E. MOUL HOME	6/30/2016	6/30/2015	6/30/2014

PG13 Median	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
	$235.36	$70.99	$48.74

PG13 Price	*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*
	$275.37	$79.51	$50.69

Median Peer Group	*Current Provider Name*	*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*
13	GOOD SHEPHERD HOME RAKER CENTER	6/30/2016	6/30/2015	6/30/2014
13	GOOD SHEPHERD HOME-BETHLEHEM	6/30/2016	6/30/2015	6/30/2014
13	INGLIS HOUSE	6/30/2016	6/30/2015	6/30/2014
13	MARGARET E. MOUL HOME	6/30/2016	6/30/2015	6/30/2014

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PG13 Median		*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*		
		$239.86	$103.97	$48.05		
PG13 Price		*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*		
		$280.64	$116.45	$49.97		
Median Peer Group	*Current Provider Name*		*Most Recent Cost Report End Date*	*Second Most Recent Cost Report End Date*	*Third Most Recent Cost Report End Date*	
14	BARNES-KASSON COUNTY HOSPITAL SNF		6/30/2016	6/30/2015	6/30/2014	
14	BERWICK RETIREMENT VILLAGE NRSNG HOME I		6/30/2016	6/30/2015	6/30/2014	
14	BUCKTAIL MEDICAL CENTER		6/30/2016	6/30/2015	6/30/2014	
14	FULTON COUNTY MEDICAL CENTER LTCU		6/30/2016	6/30/2015	6/30/2014	
14	GUTHRIE TOWANDA MEMORIAL HOSPITAL SNU		6/30/2016	6/30/2015	6/30/2014	
14	HAVEN SKILLED REHABILITATION AND NURSING		6/30/2016	6/30/2015	6/30/2014	
14	PINECREST MANOR		6/30/2016	6/30/2015	6/30/2014	
14	ST LUKE'S REHABILITATION AND NURSING CTR		6/30/2016	6/30/2015	6/30/2014	
14	SUMMIT AT BLUE MOUNTAIN NURSING & REHAB		6/30/2016	6/30/2015	6/30/2014	
14	SUNBURY COMMUNITY HEALTH & REHAB CENTER		12/31/2016	12/31/2015	12/31/2014	
14	SUSQUEHANNA HLTH SKILLED NSG & REHAB CTR		6/30/2016	6/30/2015	6/30/2014	
14	UPMC COLE SKILLED NURSING & REHAB UNIT		6/30/2016	6/30/2015	6/30/2014	
14	WILLOWCREST		6/30/2016	6/30/2015	6/30/2014	
PG14 Median		*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*		
		$165.68	$64.18	$29.49		
PG14 Price		*Resident Care 5.12*	*Other Resident Rltd*	*Administrative*		
		$193.85	$71.88	$30.67		

Source

The provisions of this Appendix B adopted January 19, 1996, effective for services rendered from January 1, 1996 through June 30, 1996, 26 Pa.B. 262; amended October 25, 1996, effective for services rendered from July 1, 1996 to June 30, 1997, 26 Pa.B. 5159; amended November 7, 1997, effective for services rendered from July 1, 1997 through June 30, 1998, 27 Pa.B. 5818; amended December 18, 1998, effective for services rendered July 1, 1998 through June 30, 1999, 28 Pa.B. 6236; amended July 30, 1999, effective for services rendered from July 1, 1999 through June 30, 2000, 29 Pa.B. 4120; amended February 25, 2000, effective for services rendered from July 1, 1998 through June 30, 1999, 30 Pa.B. 1184; amended to recind 29 Pa.B. 4120 and correct February 25, 2000, effective for services rendered from July 1, 1999 through June 30, 2000, 30 Pa.B. 1198; amended July 28, 2000, effective for services for the period July 1, 2000 through June 30, 2001, 30 Pa.B. 3858; amended September 13, 2002, effective for services rendered from July 1, 2001 through June 30, 2002, 32 Pa.B. 4536; amended January 16, 2003, effective for services rendered from July 1, 2002 through June 30, 2003, 33 Pa.B. 441; amended December 23, 2004, effective for services rendered from July 1, 2003 through June 30, 2004, 34 Pa.B. 6789; amended October 21, 2005; effective for services rendered from July 1, 2004 through June 30, 2005; 35 Pa.B. 5873; amended March 17, 2006, effective for services rendered from July 1, 2005 through June 30, 2006, 36 Pa.B. 1304; amended September 28, 2007, effective for services rendered from July 1, 2006 through June 30, 2007, 37 Pa.B. 5327; amended February 1, 2008, effective for services rendered from July 1, 2007 through June 30, 2008, 38 Pa.B. 670; amended May 8, 2009, effective for services rendered from July 1, 2008 through June 30, 2009, 39 Pa.B. 2404; amended March 4, 2011, effective for services rendered from July 1, 2009 through June 30, 2010, 41 Pa.B. 1268; amended September 30, 2011, effective July 1, 2010 through June 30, 2011, 41 Pa.B. 5247; amended June 6, 2014, effective July 1, 2011 through June 30, 2012, 44 Pa.B. 3395; amended June 6, 2014, effective July 1, 2012 through June 30, 2013, 44 Pa.B. 3419; amended June 6, 2014, effective July 1, 2013 through June 30, 2014, 44 Pa.B. 3441; amended September 19, 2014, effective July 1, 2014, through June 30, 2015, 44 Pa.B. 6028; amended June 24, 2016, effective July 1, 2015, through June 30, 2016, 46 Pa.B. 3360; amended February 17, 2017, effective July 1, 2016, through June 30, 2017, 47 Pa.B. 1062; amended December 22, 2017, effective July 1, 2017, through June 30, 2018, 47 Pa.B. 7774; amended November 30, 2018, effective July 1, 2018, through June 30, 2019, 48 Pa.B. 7466. Immediately preceding text appears at serial pages (389220) to (389246).

APPENDIX C. [Reserved]

Source

The provisions of this Appendix C adopted January 9, 1998, effective January 12, 1998, 28 Pa.B. 138; reserved April 2, 2010, effective April 3, 2010, 40 Pa.B. 1766. Immediately preceding text appears at serial pages (332529) to (332532).

[Next page is 1189-1.]