

**New York State 10 NYCRR 86-2.10 Computation of Basic Rate**

**Title 10. Department of Health  
Chapter II. Administrative Rules and Regulations  
Subchapter L. Hospitals and Related Facilities  
Part 86. Reporting and Rate Certifications for Facilities  
Subpart 86-2. Residential Health Care Facilities  
10 NYCRR 86-2.10 Computation of basic rate**

**(a)** Definitions. For purposes of this section, the following definitions shall apply:

**(1)** Direct price shall mean the monetary amount established for the direct component of the rate, based on the direct costs of all facilities after application of the regional direct input price adjustment factor, divided by patient days and the average statewide case mix index.

**(2)** Indirect price shall mean the monetary amount established for the indirect component of the rate, based on the indirect costs for each facility in a peer group, after application of a regional indirect price adjustment factor, divided by total peer group patient days.

**(3)** Peer group shall mean a set of facilities distinguished by like characteristics which are grouped for purposes of comparing costs and establishing payment rates using such criteria as affiliation (i.e., hospital-based or freestanding) case mix index (i.e., high intensity, case mix index greater than .83, or low intensity, case mix index less than or equal to .83), and size (i.e., less than 300 beds or 300 or more beds).

**(4)** Cost center shall mean categories into which related costs are grouped in accordance with and defined in Part 455 of this Title.

**(5)** Case mix index shall mean the numeric weighting of each patient classification group in terms of relative resource utilization as specified in Appendix 13-A, infra.

**(6)** Rate shall mean the aggregate governmental payment to facilities per patient day as defined in section 86-2.8 of this Subpart, for the care of Medicaid payments which include a direct, indirect, noncomparable and capital component.

**(7)** Operating portion of the rate shall mean the portion of the rate consisting of the direct, indirect and noncomparable components after application of the roll factor promulgated by the department.

**(8)** Roll factor shall mean the cumulative result of multiplying one year's trend (inflation) factor times one or more other years trend factor(s) which is used to inflate costs from a base period to a rate period.

**(9)** Capital costs shall mean costs reported in the depreciation, leases and rentals, interest on capital debt and/or major movable equipment depreciation cost centers, as well as costs reported in any other cost center under the major natural classification of depreciation, leases and rentals on the facilities annual cost report (RHCF-4).

**(10)** Base shall mean, as applicable to cost or price, a minimum cost or price.

**(11)** Ceiling shall mean, as applicable to cost or price, a maximum cost or price.

**(12)** Corridor shall mean the difference between a base and a ceiling.

**(13)** Hospital-based shall mean as follows:

**(i)** For facilities receiving initial operating certificates prior to January 1, 1983, hospital-based shall mean those facilities that are considered by the Federal Health Care Financing Administration (HCFA) to be hospital-based or hospital-related (as pertaining to cost allocation) and which derive and report costs on the basis of a Medicare cost allocation methodology from an affiliated hospital.

**(ii)** For facilities receiving operating certificates after January 1, 1983, the commissioner shall review and determine whether or not such facilities are hospital-based utilizing the following criteria:

**(a)** the nature of any construction approval received pursuant to section 2802 of the Public Health Law;

**(b)** the nature of any establishment approval received pursuant to section 2801-a of the Public Health Law;

**(c)** the architectural configuration of the residential health care facility unit as related to the hospital physical plant;

**(d)** the method and amount of cost allocation;

**(e)** whether a determination that such a facility is hospital-based would result in the efficient and economic operation of such facility.

**(b)**

**(1)** The rate for 1986 and subsequent rate years shall:

**(i)** be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ending December 31, 1983 as contained in parts I, II, III and IV of the facility's annual cost report (RHCF-4) and for hospital-based facilities, the annual cost report (RHCF-2) and the institutional cost report of its related hospital;

**(ii)** consist of the following four separate and distinct components, as defined in this section:

**(a)** direct;

**(b)** indirect;

**(c)** noncomparable; and

**(d)** capital.

**(2)** The operation portion of the rate for 1986 and subsequent rate years shall consist of the sum of the direct, indirect and noncomparable components of the rate determined in accordance with this section trended to the rate year by the applicable roll factor promulgated by the department.

**(3)** Allocation and adjustments of reported costs.

**(i)** The computation of the rate for 1986 and for subsequent rate years shall incorporate the use of the single step-down method of cost allocation as defined in section 451.249 of this Title.

**(ii)** Individual discrete ceilings shall be applied to remuneration for the facility's administrator, assistant administrator and operator as specified in Appendix 13-A, *infra*.

**(iii)** Reported costs for 1983 shall be adjusted through the apportionment of retroactive adjustments due to operating appeals which were as a result of significant increases in staff specifically mandated by the commissioner. Such adjustments shall be limited to those related to staff hired subsequent to December 31, 1982 and those appeal requests received by the department prior to July 1, 1985.

**(iv)** In the determination of rates, reported costs shall be subject to the limitations and adjustments contained in sections 86-2.12, 86-2.17, 86-2.18, 86-2.25 and 86-2.26 of this Subpart.

**(v)** Salaries paid to related parties shall be subject to an initial maximum not to exceed \$17,000. This limitation may be waived by the department pursuant to the provisions of section 86-2.14(a)(7) of this Subpart.

**(c)** Direct component of the rate.

**(1)** Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted

from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

**(i)** nursing administration;

**(ii)** activities;

**(iii)** social service;

**(iv)** transportation;

**(v)** physical therapy;

**(vi)** occupational therapy;

**(vii)** speech and hearing therapy --(speech therapy portion only);

**(viii)** pharmacy;

**(ix)** central service supply; and

**(x)** residential health care facility.

**(2)** For purposes of calculating the direct component of the rate, the department shall utilize the allowable direct costs reported by all facilities with the exception of specialty facilities as defined in subdivision (i) of this section.

**(3)** The statewide mean, base and ceiling direct price for patients in each patient classification group shall be determined as follows:

**(i)** Allowable costs for the direct cost centers for each facility after first deducting capital costs and items not subject to trending, shall be multiplied by the appropriate Regional Direct Input Price Adjustment Factor ( "RDIPAF"), as determined pursuant to paragraph (5) of this subdivision. The RDIPAF neutralizes the difference in wage and fringe benefit costs between and among the regions caused by differences in the wage scale of each level of employee.

**(ii)** The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing the patient data obtained in the patient assessment period, March 1, 1985 through September 30, 1985, conducted pursuant to section 86-2.30 of this Subpart.

**(iii)** A statewide mean direct case mix neutral cost, a statewide base direct case mix neutral cost and a statewide ceiling direct case mix neutral cost shall be determined as follows:

**(a)** Allowable direct costs for each facility, after first deducting capital costs and items not subject to trending and adjusted by applying the RDIPAF shall be summed to determine total statewide direct costs.

**(b)** The aggregate statewide case mix index shall be determined by multiplying number of patients on a statewide basis in each patient classification group by the case mix index for each patient classification group and the results summed.

**(c)** A statewide mean direct cost per day shall be determined by dividing total statewide direct costs by the aggregate number of statewide 1983 patient days.

**(d)** A statewide mean direct case mix neutral cost per day shall be determined by dividing the statewide mean direct cost per day by the ratio of the aggregate statewide case mix index to the number of patient review instruments received pursuant to section 86-2.30 of this Subpart.

**(e)** The statewide mean direct case mix neutral cost per day shall be the basis to establish a corridor between the statewide base direct case mix neutral cost per day and the statewide ceiling direct case mix neutral cost per day.

**(f)** The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the statewide mean direct case mix neutral cost per day.

**(g)** A statewide base direct case mix neutral cost per day shall be determined by multiplying the base factor times the statewide mean direct case mix neutral cost per day.

**(h)** A statewide ceiling direct case mix neutral cost per day shall be determined by multiplying the ceiling factor times the statewide mean direct case mix neutral cost per day.

**(i)** A statewide mean direct price per day for each patient classification group shall be determined by multiplying the statewide mean direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

**(j)** A statewide base direct price per day for each patient classification group shall be determined by multiplying the statewide base direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

**(k)** A statewide ceiling direct price per day for each patient classification group shall be determined by multiplying the statewide ceiling direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

**(l)** The corridor referred to in clause (e) of this subparagraph shall be calculated as follows:

**(1)** The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1986 through December 31,

1986. For the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through June 30, 1989, such factor shall be increased to approximately 95 percent. For the period July 1, 1989 through March 31, 1990, such factor shall be reduced to approximately 88.25 percent. For the period April 1, 1990, and thereafter, such factor shall be increased to approximately 90 percent.

**(2)** The ceiling factor referred to in clause (f) of this subparagraph shall be approximately 115 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be reduced to approximately 110 percent. For the period January 1, 1988 through December 31, 1988, and thereafter, such factor shall be reduced to approximately 105 percent.

**(3)** For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in the clause shall initially be determined to result in a 20-percent corridor. The ceiling factor shall then be increased by five percent. For the period January 1, 1987 through December 31, 1987, the application of the base factor and ceiling factor contained in this clause shall result in a 20-percent corridor. For the period January 1, 1988 through December 21, 1988, and thereafter, the base factor and ceiling factor contained in this clause shall result in a 10-percent corridor.

**(4)** The facility specific direct adjusted payment price per day shall be determined as follows:

**(i)** The facility specific mean direct price per day shall be determined by multiplying the statewide mean direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

**(ii)** The facility specific base direct price per day shall be determined by multiplying the statewide base direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

**(iii)** The facility specific ceiling direct price per day shall be determined by multiplying the statewide ceiling direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

**(iv)** The facility specific cost based direct price per day shall be determined by dividing a facility's adjusted allowable reported direct costs after first deducting capital costs and items not subject to trending and, after application of the RDIPAF, by the facility's 1983 total patient days.

Facility Specific Cost Based Direct	Facility Specific Direct Adjusted
Price Per Day	Payment Price Per Day
Below Facility Specific Base Direct	Facility Specific Base Direct Price
Price Per Day	Per Day
Between Facility Specific Base Direct	Facility Specific Cost Based Direct
Price Per Day and Facility	Price Per Day
Specific Ceiling Direct Price Per Day	
Above Facility specific ceiling Direct	Facility Specific Ceiling Direct Price
Price Per Day	Per Day

**(v)** Except as contained in subparagraph (vi) of this paragraph, the facility specific direct adjusted payment price per day shall be determined by comparison of the facility specific cost based price per day with the facility specific base direct price per day and the facility specific ceiling direct per day pursuant to the following table:

**(vi)** The facility specific direct adjusted payment price per day shall be considered to be the facility specific cost based direct price per day when such price is below the facility specific base direct price per day subject to the provisions of paragraph (6) of this subdivision for the following operators of residential health care facilities:

**(a)** an operator who has had an operating certificate revoked pursuant to section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an order of the Commissioner of this department; and

**(b)** an operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to section 1866(f) of the Federal Social Security Act until the lifting of the ban in writing by HCFA.

**(vii)** The direct component of a facility's rate shall be the facility specific direct adjusted payment price per day determined in subparagraph (v) or (vi) of this paragraph as applicable after applying the RDIPAF.

**(5)** The RDIPAF shall be based on the following factors:

**(i)** Residential health care facilities shall be grouped, by county, into 16 regions within the State as outlined in Appendix 13-A, *infra*.

**(ii)** The facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the PRI's submitted by each facility for the fourth quarter of the preceding calendar year, in accordance with section 86-2.11(b) and 86-2.30 of this Subpart. Until such PRI's are available, the case mix predicted staffing shall be based on the most current PRI's available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRI's for the fourth quarter of the preceding calendar year are available.

**(iii)** The proportion of salaries and fringe benefit costs for the direct care cost centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.

**(6)** Case mix adjustment. A facility shall receive an increase or decrease in the direct component of its rate if the facility has increased or decreased its case mix from one assessment period to the next and, in accordance with subparagraph

(4)(v) of this subdivision, would not have received any change in the direct component of its rate from that determined as of January 1, 1986 to the current calculation date. The increases or decreases in the direct component of the rate shall be determined as follows:

(i) The facility specific mean price per day effective January 1, 1986 as determined in accordance with subparagraph (4)(i) of this subdivision shall be compared to the facility specific mean price per day determined as a result of the submissions required in accordance with section 86-2.11(b) of this Subpart. Any increase or decrease determined as a result of such comparison, shall be expressed as a percentage, positive or negative, of the facility specific mean price per day effective January 1, 1986.

(ii) This percentage shall be applied to the facility specific cost based direct price per day determined as of January 1, 1986, and an adjustment factor shall be determined.

(iii) This adjustment factor shall be added to or subtracted from the facility specific cost based direct price per day determined as of January 1, 1986, to arrive at an adjusted facility specific cost based direct price per day which shall become for a facility their facility specific adjusted payment price per day for the applicable rate period for which payment rates are adjusted pursuant to section 86-2.11 of this Subpart.

(d) Indirect component of the rate.

(1) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

(i) fiscal services;

(ii) administrative services;

**(iii)** plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);

**(iv)** grounds;

**(v)** security;

**(vi)** laundry and linen;

**(vii)** housekeeping;

**(viii)** patient food services;

**(ix)** cafeteria;

**(x)** nonphysician education;

**(xi)** medical education;

**(xii)** housing; and

**(xiii)** medical records.

**(2)** For the purposes of establishing the allowable indirect component of the rate, facilities shall be combined into peer groups as follows:

**(i)** Size:

**(a)** less than 300 beds;

**(b)** 300 or more beds.

**(ii)** Affiliation:

**(a)** free-standing;

**(b)** hospital-based.

**(iii)** Case mix index:

**(a)** high intensity, case mix index greater than .83;

**(b)** low intensity, case mix index less than or equal to .83.

**(3)** If any peer group contains fewer than five facilities, those facilities shall be included in a peer group of a similar type.

**(4)** For each of the peer groups, the indirect component of the rate shall be determined as follows:

**(i)** A mean indirect price per day shall be computed as follows:

**(a)** Reported allowable costs for the indirect cost centers for each facility in the peer group, after first deducting capital costs and allowable items not subject to trending

shall be adjusted by applying the Regional Indirect Input Price Adjustment Factor (RIIPAF), as determined pursuant to paragraph (7) of this subdivision.

**(b)** The results of the calculation in clause (a) of this subparagraph shall be aggregated and divided by total 1983 patient days of all facilities in the peer group.

**(ii)** The mean indirect price per day shall be the basis to establish a corridor between the base indirect price per day and the ceiling indirect price per day. The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the mean indirect price per day.

**(a)** The base factor shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be increased to approximately 95 percent. For the period January 1, 1988 through June 30, 1989, such factor shall be increased to approximately 97.5 percent. For the period July 1, 1989 through March 31, 1990 such factor shall be reduced to approximately 90.75 percent. For the period April 1, 1990, and thereafter, such factor shall be increased to approximately 92.5 percent.

**(b)** The ceiling factor shall be approximately 110 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, and thereafter, such factor shall be reduced to approximately 105 percent.

**(iii)** For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph, shall result in a 20-percent corridor. For the period January 1, 1987 through December 31, 1987, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall result in a 10-percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall initially be determined to result in a five-percent corridor. The ceiling factor shall then be increased by 2.5 percent.

**(iv)** The base indirect price per day shall be determined by multiplying the base factor times the mean indirect price per day.

**(v)** The ceiling indirect price per day shall be determined by multiplying the ceiling factor times the mean indirect price per day.

**(vi)** The facility specific indirect adjusted payment price per day shall be determined by comparison of a facility's adjusted reported indirect costs after deducting capital costs and items not subject to trending and after application of the RIIPAF, divided by the facility's total 1983 patient days, with the base indirect price per day and the ceiling indirect price per day. Except as outlined in subparagraph

Facility Adjusted Costs	Facility Specific Indirect Adjusted Payment
Divided by Patient Days	Price Per Day
Below Base Indirect Price Per Day	Base Indirect Price Per Day
Between Base Indirect Price Per Day and Ceiling Indirect Price Per Day	Reported Adjusted Costs Per Day
Above Ceiling Indirect Price Per Day	Ceiling Indirect Price Per Day

**(vii)** of this paragraph, the facility specific indirect adjusted payment price per day shall be established as presented by the following table:

**(vii)** The facility specific indirect adjusted payment price per day shall be considered to be the facility specific cost based indirect price per day when such price is below the facility specific base indirect price per day for the following operators of residential health care facilities:

**(a)** an operator who has had an operating certificate revoked pursuant to section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an order of the commissioner of this department; and

**(b)** an operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to section 1866(f) of the Federal Social Security Act until the lifting of the ban in writing by HCFA.

**(5)** For each rate year, a facility's indirect costs shall be compared to the peer groups identified in paragraph (2) of this subdivision as follows:

**(i)** A facility's peer group established pursuant to subparagraphs (2)(i) and (ii) of this subdivision shall be based on that facility's affiliation status prior to the effective rate period, contingent upon the provisions of section 86-2.34 of this Subpart, and total certified bed capacity listed on the operating certificate.

**(ii)** Those facilities having 80 percent or more of all patients falling into patient classification groups with weights greater than .83 shall be compared to the peer group established pursuant to clause (2)(iii)(a) of this subdivision.

**(iii)** Those facilities having 80 percent or more of all patients falling into patient classification groups with weights equal to or less than .83 shall be compared to the peer group established pursuant to clause (2)(iii)(b) of this subdivision.

**(iv)** Those facilities who do not meet either of the above conditions identified in subparagraphs (ii) and (iii) of this paragraph, shall be compared to a blended peer group mean price per day. Such price shall be determined by blending the number of a facility's patients which have patient classification group weights above .83 at the high intensity peer group mean price and the number of a facility's patients at or below .83 at the low intensity peer group mean price as defined pursuant to paragraph (4) of this subdivision.

**(v)** The peer group mean price effective January 1st of each rate year shall be based on the PRI's submitted by each facility for the fourth quarter of the preceding calendar year in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRI's are available, the peer group mean price shall be based on the most current PRI's available prior to calculation of the initial rate effective January 1st of each rate year. The peer group mean price shall subsequently be revised based on more recent PRI submissions until such time as the PRI's for the fourth quarter of the preceding calendar year are available.

**(6)** The indirect component of a facility's rate shall be the facility specific indirect adjusted payment price per day determined in accordance with subparagraphs (vi) and (vii), as applicable of paragraph (4) of this subdivision after application of the RIIPAF.

**(7)** The RIIPAF shall be based on the following factors:

**(i)** residential health care facilities shall be grouped by county, into 16 regions within the State as outlined in Appendix 13-A, *infra*.

**(ii)** the facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st, of each rate year based on the PRI's submitted by each facility for the fourth quarter of the preceding calendar year, in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRI's are available, the case mix predicted staffing shall be based on the most current PRI's available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRI's for the fourth quarter of the preceding calendar year are available; and

**(iii)** the proportion of salaries and fringe benefit costs for the indirect care cost centers indicated in paragraph (1) of this subdivision to the total costs of such indirect care cost centers.

**(e)** Gain or loss limitation for the direct and indirect component of the rate. Gain or losses resulting from using the regional direct or indirect input price adjustment factors rather than individual facility specific direct or indirect input price adjustment factors shall be determined as follows:

**(1)** A facility's allowable direct costs divided by the facility's 1983 total patient days shall be compared to the facility's direct component and a direct gain or loss per day calculated.

**(2)** A facility's allowable indirect costs divided by the facility's 1983 total patient days shall be compared to the facility's indirect component and an indirect gain or loss per day calculated.

**(3)** The facility's direct gain or loss per day and indirect gain or loss per day shall be summed to arrive at a facility's net composite gain or loss per day.

**(4)** If a facility's net composite gain or loss per day is greater than \$3.50, for the rate year 1986, a limitation shall be applied for rate years 1986 through 1988 as follows:

**(i)** For 1986 rates, if a facility has a net composite gain, then a facility's direct or indirect cost per day shall be determined by utilizing the regional or the individual facility specific input price adjustment factor, whichever factor, when applied would reduce the gain.

**(ii)** For 1986 rates, if a facility has a net composite loss, then a facility's direct or indirect cost per day shall be determined by utilizing the regional or the individual facility specific input price adjustment factor, whichever factor, when applied, would reduce the loss.

**(iii)** If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the regional input price adjustment factor, such factor shall be utilized in all subsequent rate years.

**(iv)** If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the individual facility specific input price adjustment factor, the following shall apply to subsequent rate years:

**(a)** For 1987 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 50 percent of the regional and 50 percent of the facility specific input price adjustment factor.

**(b)** For 1988 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 75 percent of the regional and 25 percent of the facility specific input price adjustment factor.

**(c)** For 1989 and subsequent rate years, a facility's direct costs per day shall be determined by using the regional input price adjustment factors.

**(5)** The limitations of this subdivision shall not be applicable to specialty facilities as defined in subdivision (i) of this section.

**(f)** Noncomparable component of the rate.

**(1)** The noncomparable component of the rate shall consist of costs which represent allowable costs reported by a facility which because of their nature are not subject to peer group comparisons.

**(2)** Allowable costs for the noncomparable component of the rate shall include the costs associated with supervision of facility volunteers and costs reported in the following functional cost centers as reported on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting capital costs and allowable items not subject to trending:

**(i)** laboratory services;

**(ii)** ECG;

**(iii)** EEG;

**(iv)** radiology;

**(v)** inhalation therapy;

**(vi)** podiatry;

**(vii)** dental;

**(viii)** psychiatric;

**(ix)** speech and hearing therapy --(hearing therapy only);

**(x)** medical director office;

**(xi)** medical staff services;

**(xii)** utilization review;

**(xiii)** other ancillary; and

**(xiv)** plant operations and maintenance --(cost for utilities and real estate and occupancy taxes only).

**(3)** The allowable facility specific noncomparable component of the rate shall be reimbursed at a payment rate equal to adjusted reported noncomparable costs, after first deducting capital costs and allowable items not subject to trending, divided by the facility's total 1983 patient days.

**(g)** Capital component of the rate. The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with sections 86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the department to be nontrendable divided by the facility's patient days in the base year determined applicable by the department.

**(h)** A facility's payment rate for 1986 and subsequent rate years shall be equal to the sum of the operating portion of the rate as defined in paragraph (b)(2) of this section and the capital component as defined in subdivision (g) of this section.

**(i)** Specialty facilities. Facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems shall be considered specialty facilities and shall not be subject to the provisions of paragraphs (c)(3), (c)(4), (d)(4), (d)(5) and (d)(6) of this section. The direct component of such facilities' rates shall be calculated based on allowable 1983 direct costs as defined in paragraph (c)(1) of this section, divided by the facilities' total 1983 patient days. The indirect component of such facilities' rates shall be calculated based on allowable 1983 indirect costs as defined in paragraph (d)(1) of this section, divided by the facilities' total 1983 patient days.

**(j)** Rates for residential health care facility services for nonoccupants for 1986 and subsequent rate years shall be calculated in accordance with section 86-2.9 of this Subpart, with any operating component of the rate trended from the 1983 base year, to the rate year by the applicable roll factor promulgated by the department.

**(k)** Receiverships and new operators.

**(1)** The appointment of a receiver or the establishment of a new operator to an ongoing facility shall require such receiver or operator of file a cost report for the first 12-month period of operation in accordance with section 86-2.2(e) of this Subpart. This report shall be filed and properly certified within 60 days following the end of the 12-month period covered by the report. Failure to comply with this subdivision shall result in application of the provisions of section 86-2.2(c) of this Subpart.

**(2)** The initial rate for facilities covered under this subdivision shall be the higher of:

**(i)** the rate in effect on the date of the appointment of a receiver or the date of transfer of ownership as applicable; or

**(ii)** the rate in effect on the date of appointment of a receiver or the date of transfer of ownership as applicable with the direct and indirect component of such rate calculated as follows:

**(a)** the direct component of the rate shall be equivalent to the facility-specific mean direct price per day after application of the RDIPAF as determined in subdivision (c) of this section. The PRIs used in the computation of the facility-specific mean direct price per day shall be the PRIs used to calculate the rate in effect on the date of appointment of a receiver or the date of transfer of ownership;

**(b)** the indirect component of the rate shall be equivalent to the mean indirect price per day, determined using the PRIs used to calculate the rate in effect on the date of appointment of a receiver or date of transfer of ownership, and adjusted by the RIIPAF as determined in subdivision (d) of the section.

**(3)** The facility shall perform an assessment of all patients, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation. The direct component of the rate shall be adjusted pursuant to this Subpart effective the first day of the assessment period based on the facility's case mix.

**(4)** The 12-month cost report referred to in paragraph (1) of this subdivision shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the 12-month cost report period.

**(5)**

**(i)** For purposes of this subdivision, and except, as identified in paragraph (7) of this subdivision, the terms new operator and receiver shall not include any operator or receiver approved to operate a facility when:

**(a)** a stockholder, officer, director, sole proprietor or partner of such operator or receiver was also a stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility;

**(b)** the approved operator was the prior receiver of the facility;

**(c)** any prior corporate operator or receiver is a corporate member of the approved operator or receiver, is otherwise affiliated with the approved operator or receiver through direct or indirect sponsorship or control or when the approved operator or receiver and prior operator or receiver are subsidiaries of a common corporate parent; or

**(d)** a principal stockholder (owning 10 percent or more of the stock), officer, director, sole proprietor or partner of an approved proprietary operator or receiver is the spouse or child of a principal stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility, regardless of whether such relationship arises by reason of birth, marriage or adoption.

**(ii)** Rates of reimbursement for operators or receivers which are not considered new operators or receivers under this subdivision shall not be subject to adjustment under this subdivision.

**(6)** Notwithstanding the provisions of this subdivision, a receiver or new operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993 but after the date on which the receiver was appointed or new operator became the operator shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for the purposes of this subdivision in lieu of the 12-month cost report identified in paragraph (1) of this subdivision.

**(7)**

**(i)** Notwithstanding the provisions of this subdivision, when a receiver of a proprietary nursing facility is appointed or a new operator of a previously established proprietary nursing facility is established and a stockholder, sole proprietor, partner or limited liability company member of such receiver or new operator is the child of a stockholder, sole proprietor, partner or member of the limited liability company of the prior operator or receiver of the facility, such receiver or new operator shall receive rates of reimbursement adjusted pursuant to paragraphs (1)-(4) and (6) of this subdivision. For purposes of this paragraph, child shall mean a child or stepchild by birth, adoption, or marriage. Rates of reimbursement for any subsequent operator of such facility who is established within 10 years of the date of appointment or establishment of such child or stepchild shall not be subject to adjustment under this subdivision.

**(ii)** For purposes of this paragraph, the terms new operator and receiver shall not include any operator or receiver with a stockholder, sole proprietor, partner, or limited liability company member who was a stockholder, sole proprietor, partner or limited liability company member of the prior operator or receiver of such facility.

**(iii)** For purposes of this paragraph, new operator shall also mean an established operator which has undergone a total change in owners, stockholders, partners or limited liability company members.

**(iv)** This paragraph shall apply to appointments of receivers and/or the establishment of a new operator on or after the effective date of this paragraph.

**(1)** Adjustments to the operating component of the rate. (1) Notwithstanding any other provision of this section, the department shall make available the sum of \$10 million for rate year 1986 and \$5million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

**(2)** To determine eligibility for such adjustments, facilities shall also have suffered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility's composite reimbursement for the direct and indirect components of the rate is less than such a facility's composite 1983 allowable costs for the direct and indirect components.

**(3)** The transfer amount referred to in paragraph (1) of this subdivision shall be made available by reductions in the operating components of facilities' rates whose composite reimbursement for the direct and indirect components of their rates is more than their composite 1983 allowable costs for the direct and indirect components, herein referred to as aggregate gains.

**(4)** The transfer amounts referred to in paragraph (1) of this subdivision shall be distributed, for the applicable rate years, to eligible facilities by a per diem adjustment in the operating component of their rates in accordance with the following procedure:

**(i)** The indirect losses of all eligible facilities shall be summed to arrive at total indirect losses.

**(ii)** The proportion of a facility's indirect loss to total indirect losses shall be expressed as a percentage, herein referred to as a sharing percentage.

**(iii)** The sharing percentage for an eligible facility shall be multiplied by the transfer amount to arrive at a facility's share of the transfer amount.

**(iv)** A facility's share of the transfer amount shall be divided by 1983 patient days to arrive at a per diem adjustment to the operating component of a facility's rate.

**(5)** The transfer amounts referred to in paragraph (1) of this subdivision shall be accumulated from facilities referred to in paragraph (3) of this subdivision by a per diem adjustment to the operating component of their rates in accordance with the following procedure:

**(i)** The aggregate gains of a facility shall be expressed as a percentage of their composite 1983 allowable costs for the direct and indirect components. Such percentage shall be herein referred to as percentage gain.

**(ii)** The percentage gain for all facilities shall be ranked from highest to lowest.

**(iii)** A methodology shall be employed where, beginning with a set percentage, percentage gains in excess of such set percentage shall be noted, arrayed by facility and herein referred to as excess percentage gain.

**(iv)** The excess percentage gain shall be multiplied by each facility's allowable composite 1983 costs for the direct and indirect components and such total for all facilities accumulated as a funded amount. The excess percentage gain shall also then be subtracted from a facility's percentage gain and the net percentage gain utilized as a facility's percentage gain for subsequent calculations.

**(v)** Such process shall continue, decreasing the set percentage used as a standard against which percentage gains of facilities is compared and the funded amounts accumulated until the transfer amounts referred to in paragraph (1) of this subdivision are realized.

**(vi)** If in this process, moving to the next set percentage used as a standard against which percentage gains of facilities is compared shall result in a total transfer amount in excess of the transfer amounts referred to in paragraph (1) of this subdivision, the following procedure shall be utilized to determine the amounts necessary to be funded by each facility in the final step of this process to attain the transfer amounts referred to in paragraph (1) of this subdivision:

**(a)** A facility's percentage gain shall be compared to the next lower set percentage that would be utilized as a standard and an excess percentage gain determined.

**(b)** The excess percentage gain for a facility, at that time, shall be multiplied by the facility's allowable composite 1983 costs for the direct and indirect components and the result herein referred to as an interim funded amount.

**(c)** The interim funded amount for each facility, expressed as a percentage of the aggregate of the interim funded amounts for all facilities shall be multiplied by the remaining amount to be funded for a given rate year to arrive at a facility's portion of the final amount to be funded.

**(vii)** The funded amounts for a facility arrived at as a result of this paragraph shall be summed, divided by total 1983 patient days and deducted as a per diem adjustment from a facility's operating per diem in the appropriate rate year.

**(m)** Computation of regional input price adjustment factors applied for purposes other than determining, pursuant to this section, the statewide direct and peer group indirect prices.

**(1)** The regional direct input price adjustment factor (RDIPAF) as contained in subparagraphs (c)(4)(iv) and (vii) of this section, the regional indirect input price adjustment factor (RIIPAF), as contained in subparagraph (d)(4)(vi) and paragraph (d)(5) of this section and the regional input price adjustment factor as contained in subparagraph (e)(4)(iv) of this section, hereinafter referred to as factors shall, for rate years beginning on or after January 1, 1987, be based on the regional average dollar per hour (RAP) calculated using the financial and statistical data required by section 86-2.2 of this Subpart, reported solely for 1983 calendar year operations, adjusted as follows:

**(i)** RAP's shall be adjusted for the variation in wage and fringe benefit costs for each region relative to such variation for all other regions through the use of a variable corridor.

**(ii)** The measurement of the region's variation shall be accomplished by means of the statistical measure of variation, the coefficient of variation, in wage and fringe benefit costs.

**(iii)** The region with the smallest variation shall receive no corridor. The region with the highest variation shall receive a corridor no greater than a maximum percentage such that the average corridor for all regions in the State shall be approximately plus or minus 10percent.

**(iv)** For rate years beginning on or after January 1, 1991, for those regions of the State described in Appendix 13-A, infra, whose Regional Average Dollar Per Hour (RAP), calculated using the financial and statistical data required by section 86-2.2 of this Subpart reported solely for 1987 calendar year operations (1987 RAP) expressed as a percentage of the Statewide RAP for such year is greater than the percentage calculated using the same data reported for 1983 calendar year operations, (1983 RAP), the factors shall be determined utilizing 1987 RAPs and adjusted pursuant to subparagraphs (i), (ii) and (iii) of this paragraph.

**(a)** Notwithstanding this subparagraph if the utilization of 1987 RAPs to determine the factors would, for any facility within a region described in this subparagraph, result in less reimbursement than the continued utilization of the 1983 RAPs to determine the factors, the factors utilized for such facility shall continue to be based on 1983calendar year data.

**(2)** The corridor established in paragraph (1) of this subdivision shall be applied in each region as follows:

**(i)** The regional corridor percentage referred to in subparagraph (1)(iii) of this subdivision, shall be applied, both negatively and positively to the RAP to arrive at an amount which when added to or subtracted from the RAP shall represent the maximum and minimum regional dollar per hour for the region, hereinafter referred to as the maximum and minimum respectively.

**(ii)** The facility in each region with the highest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the maximum.

**(iii)** The facility in each region with the lowest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the minimum.

**(iv)** Facilities in a region with facility wage and fringe benefit dollars per hour between the highest and lowest facility wage and fringe benefit dollar per hour in such region shall be assigned a facility RAP on a sliding scale, based on the relativity of each such facility's labor costs to the RAP and to the highest or lowest labor costs in the region, as applicable.

**(n)** Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI). Facilities which have been approved to operate discrete units for the care of patients under the long-term inpatient rehabilitation program for TBI patients established pursuant to section 415.36 of this Title shall have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

**(1)** In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for patients meeting the criteria for and residing in a TBI unit, the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (c)(3) (iii) of this section for such residents shall be increased by an increment of 1.49. In determining the case mix adjustment pursuant to paragraph (c)(6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.49.

**(i)** The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.36 of this Title.

**(2)** In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4), (5) and (6) of this section for residents meeting the criteria for and residing in a TBI unit, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

**(3)** The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.36 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

**(o)**

**(1)** A per diem amount of \$4 (subject to adjustment pursuant to the provisions of paragraph [2] of this subdivision) increased to the rate year by the projection factors determined pursuant to section 86-2.12 of this Subpart, adjusted by the RDIPAF determined pursuant to paragraph (c)(5) of this section, shall be added to each facility's payment rate for each patient whose primary medical problem, as reported in section V.29 of the patient review form (PRI) as contained in section 86-2.30(i) of this Subpart, is dementia, as defined in paragraph (4) of this subdivision, and who is properly assessed and reported by the facility in one of the following patient categories as listed in Appendix 13-A of this Title:

Clinically Complex A  
Behavioral A  
Reduced Physical Functioning A  
Reduced Physical Functioning B

**(2)** Based on the most current 1986 PRI's filed with the department, the number of eligible dementia patient days for Medicaid patients admitted prior to December 31, 1987, is estimated to be 1,750,000. Aggregate changes in such number in excess of five percent shall be deemed to be attributable to factors other than changes in patient condition and shall result in the recalculation and proportionate, prospective reduction of the per diem amount referred to in paragraph (1) of this subdivision.

**(3)** Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.

## ICD-9-CM CODE

## ICD-9-CM CODE DIAGNOSIS

290.0	Senile dementia Uncomplicated senile dementia NOS, simple type excludes memory disturbance
290.1	Presenile dementia Brain syndrome with presenile brain disease Dementia in: Alzheimer's disease Jakob-Croutzfeldt disease Pick's disease of the brain
290.10	Presenile dementia Uncomplicated presenile dementia NOS, simple type
290.11	Presenile demential with delirium Presenile dementia with acute confusional state
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.2	Senile dementia with delusional or depressive features
290.21	Senile dementia with depressive features
290.4	Multi-infarct dementia

290.40	Arteriosclerotic dementia
290.41	Arteriosclerotic dementia
290.42	Arteriosclerotic dementia
290.43	Arteriosclerotic dementia
294.0	Wernicke-Korsakoff syndrome (nonalcoholic)
293.81	Organic brain syndrome
294.8	Other specified brain syndrome
294.9	Unspecified organic brain syndrome
310.1	Organic personality syndrome
310.8	Other specified nonpsychotic mental disorders, following organic brain damage
310.9	Unspecified nonpsychotic mental disorders following organic brain damage

331.0	Alzheimer's disease
331.1	Pick's disease
331.2	Senile degeneration of the brain
331.3	Communicating hydrocephalus
331.7	Cerebral degeneration in diseases classified elsewhere
331,8	Other cerebral degeneration
331.9	Cerebral degeneration, unspecified
331.89	Cerebral degeneration, NEC
333.4	Huntington's Chorea
437.0	Cerebral atherosclerosis

**(4)** The per diem amount referred to in paragraph (1) of this subdivision shall be paid for any patients with the following dementia diagnoses. The dementia diagnoses and related codes and descriptions are taken from the International Classification of Diseases, 9th Revision, Clinical Modification, volume 3 (ICD-9-CM). year 1988 and thereafter, payment

rates shall be adjusted, pursuant to this subdivision to provide additional payments to facilities for patients residing in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit approved by the commissioner pursuant to Part 710 of this Title, or a facility which has received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic. Such patients shall hereinafter be referred to as AIDS patients.

**(p)**

**(2)** Separate and distinct payment rates shall be calculated pursuant to this paragraph for AIDS facilities or discrete AIDS units approved by the commissioner pursuant to Part 710 of this Title.

**(i)** The facility specific direct adjusted payment price per day shall be determined pursuant to paragraphs (c)(3) and (4) of this section and further adjusted as follows:

**(a)** In determining the direct component of a facility's rate pursuant to paragraphs (c)(3) and (4) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the case mix index for the AIDS patient shall be increased by an increment which shall be determined on the basis of the difference between allowable actual direct staffing levels and cost expenditures for the care of AIDS patients in specific patient classification groups and those of non-AIDS patients which are classified in the same patient classification groups based on data submitted by the facility. The increment to be included in a facility's rate shall be approved by the commissioner, but in no event shall the increment exceed 1.0. The facility's direct ceiling price shall be further increased by an occupancy factor of 1.089.

**(b)** For purposes of this paragraph, the allowable costs for the central service supply functional cost center as listed in paragraph (c)(1) of this section shall be considered a noncomparable cost.

**(ii)** Except as identified in subparagraph (iii) of this paragraph, in determining the indirect component of a facility's rate pursuant to paragraphs (d)(4), (5) and (6) of this section for providing care of an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit (an approved discrete AIDS unit), the peer group ceiling indirect price shall be increased by a factor of 1.20.

**(iii)** In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4) and (5) of this section for a facility with a total bed complement of less than 40 beds all of which are approved by the commissioner pursuant to Part 710 of this Title solely for

the care management of AIDS patients, the peer group ceiling indirect price shall be increased by a factor of 2.00 for those facilities that are less than or equal to 16 beds and such factor shall be decreased by 0.033 for every additional bed thereafter.

**(3)** For facilities which have received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates pursuant to paragraph (2) of this subdivision, the patient classification group case mix index for AIDS patients which is used to establish direct cost reimbursement shall be increased by an increment of 1.0.

**(g)** Long-term ventilator dependent residents. Facilities which have been approved to operate discrete units for the care of long-term ventilator dependent residents as established pursuant to section 415.38 of this Title shall have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

**(1)** The facility-specific direct adjusted price per day shall be determined as follows:

**(i)** In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for residents meeting the criteria established in section 415.38 of this Title and residing in a discrete unit for the care of long-term ventilator dependent residents, the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (c)(3)(iii) of this section for such residents shall be increased by an increment of 1.15. In determining the case mix adjustment pursuant to paragraph (c)(6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.15.

**(ii)** The increment established in subparagraph (i) of this paragraph shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.38 of this Title.

**(iii)** The allowable costs for the central service supply functional cost center as listed in paragraph (c)(1) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

**(iv)** The allowable costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section.

**(2)** In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4), (5) and (6) of this section for residents meeting the criteria established in section 415.38 of this Title and residing in a discrete unit for the care of long-term ventilator dependent residents, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

**(3)** The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.38 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

**(r)** Nursing salary adjustment.

**(1)** The adjustment to the operating portion of the rate to reflect the costs of retaining and recruiting nursing services shall be made as follows:

**(i)** A percentage figure shall be determined as follows:

**(a)** An average annual statewide increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based on the available ratified nursing contracts for general hospital services and an average annual regional increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based upon available information for residential health care facilities.

**(b)** The average annual regional and statewide increase in salaries shall be multiplied by the total number of nursing staff in the region and the total number of nursing staff statewide respectively to arrive at the total regional and statewide adjustment to be made to facilities. The total regional adjustments shall be determined using the regions contained in Appendix 13-A, *infra*.

**(c)** The adjusted base shall be determined by multiplying the facility specific mean price per day determined pursuant to subparagraph (c)(4)(i) of this section by total patient days for each facility and the result shall be summed on a regional and statewide basis.

**(d)** The total adjustment to be made for all facilities determined pursuant to clause (b) of this subparagraph shall be divided by the adjusted base determined pursuant to clause (c) of this subparagraph on a regional and statewide basis to determine the regional percentage increase and the statewide percentage increase.

**(e)** The facility specific percentage shall be determined by summing 40 percent of the statewide percentage and 60 percent of the corresponding regional percentage determined pursuant to clause (d) of this subparagraph.

**(ii)** The adjustment to the rate for a facility shall be determined by applying the facility specific percentage figure calculated in subparagraph (i) of this paragraph to a facility's adjusted base and added to the operating portion of the rate.

**(s)** Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.

**(1)** Rate changes resulting from the amendments to sections 86-2.1(a), 86-2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) and (2), (p)(2) and (3) and 86-2.30(c)(3) of this Title effective October 1, 1990 and amendments to sections 86-2.10 (a)(3), (c)(1), (3) and (5), (d)(1), (2) and (4)-(7), (p)(1)-(3), and (t)(1) and (2) of this Title effective April 1, 1991 shall be transitioned into the rates as follows:

**(i)** For rates with effective dates commencing between October 1, 1990 and June 30, 1992, the rate shall be computed using the rate methodology in effect on September 30, 1990, adjusted by the most recent PRI submissions applicable to the effective period of the rate, and the adjustment to the regional direct and indirect input price adjustment factors pursuant to subparagraph (m)(1)(iv) of this section.

**(ii)** For rates with effective dates commencing on or after July 1, 1992, the full impact of the rate changes cited in paragraph (1) of this subdivision shall be reflected in rates.

**(iii)** Those facilities with an initial budgeted rate or revised cost-based rate which reflects a change in base year and which is effective after April 1, 1991, shall receive the full impact of the methodology changes cited in paragraph (1) of this subdivision on the effective date of such rate.

**(2)** For facilities having multiple rates based on levels of care prior to October 1, 1990, such rates shall be combined for the establishment of rates effective October 1, 1990 to June 30, 1992 based on a weighted average of reported Medicaid days for each previous level of care for the latest available cost reporting period. Where the department is authorized expressly by statute to adjust rates retrospectively, for both positive and negative rate adjustments, such combined rate shall be adjusted by a reconciliation of reported Medicaid days to actual billed Medicaid days for the effective period, provided that such adjustment results in a combined direct and indirect component rate change of more than five percent. Such combined rate shall reflect the amendments referenced in paragraph (1) of this subdivision pursuant to the schedule set forth therein.

**(3)** Notwithstanding the provisions of paragraph (1) of this subdivision, residential health care facilities which have been identified by the department as requiring registered nurse staffing increases to provide seven days a week, eight hours per day of day shift registered nurse coverage shall receive rate changes effective October 1, 1990 at a level sufficient to compensate facilities for additional expenses of expanding registered nurse coverage based upon a survey of costs to be incurred by affected facilities.

**(4)** Nothing within this subdivision shall preclude the department from fully implementing rate adjustments on or after October 1, 1990, which are unrelated to methodology changes referenced in paragraph (1) of this subdivision.

**(t)** Base year adjustment for facilities who have bed conversions. A facility shall be eligible for an adjustment to its base year costs if its proportion of beds identified as skilled nursing facility beds and health related facility beds as of the first day of its base period differs from the proportion of beds identified as skilled nursing facility beds and health related facility beds as of September 30, 1990. The adjustment shall be separately determined for the direct, indirect, and noncomparable components of a facility's allowable base period costs, and each adjustment shall be added to a facility's allowable direct, indirect and noncomparable costs, respectively, prior to group comparisons. The amount of the adjustment shall be determined as follows:

**(1)** Base period direct, indirect, and noncomparable costs per bed adjusted for occupancy level shall be separately calculated for both skilled nursing and health related facility beds. The changes in skilled nursing and health related facility beds for the period defined in the

above paragraph shall be multiplied by the applicable cost per bed and added together to arrive at each adjustment amount.

**(2)** An adjustment to allowable days shall also be made for a facility whose total number of beds has changed for the period described in this subdivision to reflect the skilled nursing facility and health related facility occupancy levels used in the calculation of rates effective September 30, 1990. Base period days shall be adjusted by the proportion of total new beds as of September 30, 1990 to total base year beds prior to the determination of the facility-specific price per day for the facility's direct, indirect, and noncomparable cost components.

**(u)** Adjustment for additional Federal requirements. A facility whose rate is based on allowable or budgeted costs for a period prior to April 1, 1991 shall be considered eligible to receive a per diem adjustment to its rate as follows:

**(1)** A per diem adjustment shall be incorporated into each facility's rate to take into account the additional reasonable costs incurred by facilities in complying with the requirements of subsection (b) (other than paragraph 3[F] thereof), (c) and (d) of section 1919 of the Federal Social Security Act effective October 1, 1990 as added by the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Additional reasonable costs resulting from such Federal requirements shall include additional reasonable costs in the following areas: the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aide registry costs, psychotropic drug reviews, and surety bond requirements.

**(i)** The per diem adjustment shall be 45 cents computed on a statewide basis and shall be regionally adjusted to reflect differences in registered nurse salary levels for calendar year 1987. Any costs over the per diem adjustment shall be deemed attributable to factors other than compliance with the Federal requirements referenced in this subdivision.

**(ii)** For purposes of inclusion in facility rates for 1991, the annual incremental per diem add-on shall be effective for the nine-month period beginning April 1, 1991 and further adjusted so that the nine months of incremental cost are reflected in a per diem adjustment for July 1, 1991 through December 31, 1991 rates.

**(2)** For rates years beginning on or after January 1, 1992 the annual incremental per diem add-on calculated pursuant to subparagraph (1)(i) of this subdivision shall be trended forward by the applicable facility trend factor.

**(v)** Extended care of residents with traumatic brain injury.

**(1)**

**(i)** Except as provided in subparagraph (ii) of this paragraph, effective April 1, 1993 a per diem amount of \$25, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, and increased in rate years thereafter, by the projection factors determined pursuant to section 86-2.12 shall be added to a facility's payment rate determined pursuant to this Subpart for each resident with traumatic brain injury identified as requiring extended care and receiving services pursuant to section 415.40 of this Title.

**(ii)** Effective with rates revised based upon patient review instrument (PRI) assessment data for an assessment period set forth in section 86-2.11(b) of this Subpart beginning on or after November 1, 1994, a TBI patient per diem amount shall be added to a facility's average Medicaid payment rate determined pursuant to this Subpart only for Medicaid residents with traumatic brain injury identified as requiring extended care and receiving services pursuant to section 415.50 of this Title. The TBI patient per diem amount shall be determined as follows: The total number of Medicaid traumatic brain injury (TBI) extended care residents shall be multiplied by \$25 per patient day times 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RDIPAF, determined pursuant to subdivision (c)(5) of this section, to establish the allowable TBI dollars. The allowable TBI dollars shall be divided by the facility total annual Medicaid days to determine the facility TBI patient per diem amount. The TBI patient per diem amount shall be increased annually by the projection factor determined pursuant to section 86-2.12 of this Subpart. For purposes of this subdivision, a Medicaid resident is defined as a resident whose primary payor description is coded as Medicaid on the PRI assessment data.

**(2)** Residents reimbursed pursuant to this subdivision shall not be reimbursed pursuant to subdivisions (n) and (o) of this section.

**(w)** Specialized programs for residents requiring behavioral interventions. Facilities which have been approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates calculated pursuant to this section except as follows:

**(1)** In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the case mix index used to establish the statewide ceiling price per day for each patient classification group pursuant to subparagraph (c)(3)(iii) of this section for such residents shall be

increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (c)(6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.40.

**(i)** The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.39 of this Title.

**(2)** In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

**(3)** The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

Authority. --Public Health Law, §§ 2803[2], 2807[3], 2808.