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A Report on Shortfalls in Medicaid Funding for Nursing Home Care

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**FOR THE
AMERICAN HEALTH CARE ASSOCIATION**

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REPORT HIGHLIGHTS

- ▶ The average shortfall in Medicaid nursing home reimbursement was projected to be \$13.15 in 2007.
- ▶ The projected daily reimbursement shortfall for 2007 is comparable to the 2006 projected shortfall of \$13.10 (per last year's report) but is a 45% increase from 1999 to 2007.
- ▶ Un-reimbursed nursing home Medicaid allowable costs were estimated at \$4.4 billion in 2007.
- ▶ States continue to rely heavily upon provider taxes to fund nursing home reimbursement.
- ▶ State nursing facility provider taxes generate an estimated \$3.8 billion in federal matching funds; a rate impact on average exceeding \$14 per Medicaid day.
- ▶ Greater use of provider taxes is limited since many states are at or near the regulatory limit, which decreases to 5.5% of patient revenues effective January 1, 2008.
- ▶ As states restructure their long term care programs, a larger share of Medicaid funding is being redirected toward home and community-based services such as the "Money Follows the Person Demonstration." If state economies downturn, this will put pressure to dampen rate increases to nursing homes, and reverse the trend achieved in nursing home funding in the past few years of rate increases, on average, keeping pace with cost increases.
- ▶ Medicare cross-subsidization of Medicaid continues to play an important role in sustaining nursing home care, even in better economic times. Even with positive Medicaid rate trends, on average, the combined margin from the two payer sources is still negative.

MEDICAID 2005 AND PROJECTED 2007 NURSING HOME SHORTFALL STUDY SUMMARY

BDO Seidman, LLP (BDO), in concert with Eljay, LLC (Eljay), was engaged by the American Health Care Association (AHCA) to work with its state affiliates and other sources to compile information on the shortfall between Medicaid reimbursement and allowable Medicaid costs in as many states as feasibly possible.¹ This year's compilation, like the previous five prepared by BDO, identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available (in this case 2005). In addition, similar to last year's study, a shortfall for the current year (2007) is projected by trending the 2005 costs (or 2006 if available) to the current year and comparing them to current Medicaid rates.

Methodology

Overall, data were obtained from 39 states and the District of Columbia for 2005² and represented over 87% of the Medicaid patient days in the country. The data from 85% of the states reporting in 2005 were based upon audited or desk-reviewed cost reports, or some blend of both. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.³

As previously indicated, in addition to determining the shortfall in Medicaid funding in 2005, BDO projected the shortfall in Medicaid reimbursement for the current year by comparing current year rates to 2005 allowable costs (or 2006 if available) trended to the current year. The trending factor used in projecting 2005 costs to the current rate year was the Medicare Skilled Nursing Facility Market Basket Index (Market Basket), the same inflation index used by most

¹ The President of Eljay, LLC is a retired partner of BDO and formerly their National Director of Long Term Care Services. Both this year's study and the five conducted in prior years were compiled under his management and review.

² The latest available audited cost data for New Hampshire were from 2004 while in Indiana, the state Medicaid contractor provided shortfall data only for the current year. Thus, a projected 2007 shortfall was determined for both of these states but a 2005 shortfall could not be determined for either due to missing data.

³ As-filed Medicaid cost reports or Medicare cost reports were the only available reports in a few states where rates were not based upon the most current cost report. In this situation, the state may not have audited the report since it was not used in the rate setting process. These cost reports, however, already excluded non-allowable costs per cost report instructions although additional adjustments would typically be made if audited by the state agency or its contractor.

states to inflate costs for rate setting purposes and also used by the Medicare program in setting Medicare rate increases. The trended costs were also increased by the cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost reports.⁴ Historically, allowable Medicaid costs have increased annually by a greater percentage than the Market Basket, meaning, once actual cost data become available, the actual shortfall for 2007 will likely be higher than what is projected in this report.

Estimated Medicaid Shortfall: 2005

The estimated average shortfall in Medicaid reimbursement increased per Medicaid patient day from \$12.58 in 2004 to \$13.43 in 2005; a 6.8% increase. Extrapolating to all 50 states, the shortfall in total nursing facility Medicaid funding in 2005 was estimated at just over \$4.6 billion.

Projected Medicaid Shortfall: 2007⁵

Between 2005 and 2007, overall Medicaid rate increases have kept pace with market basket projected cost increases, resulting in the shortfall decreasing 2.1% to an estimated \$13.15 per Medicaid patient day in 2007. The 2007 shortfall compilation incorporates data from 41 states and the District of Columbia.⁶ When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities was projected to exceed \$4.4 billion.

Taken together, in the years that we have compiled this study, the shortfall in Medicaid nursing home funding has increased 45%, from \$9.05 per patient day in 1999 to a projected \$13.15 in 2007. If all costs of operations were considered—not just Medicaid allowable costs—the

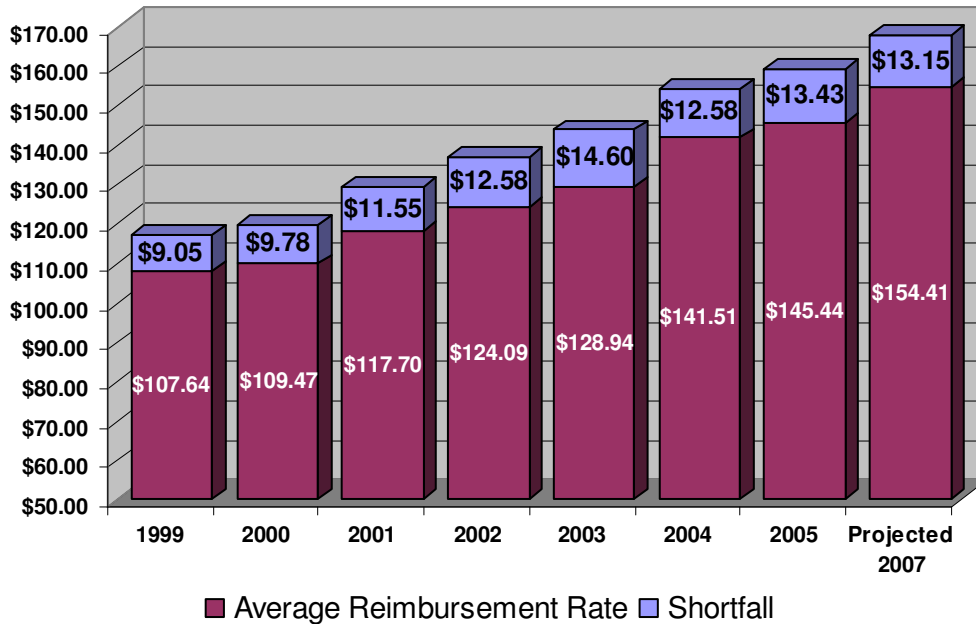
⁴ In Missouri, 2005 costs were projected to the current year by the skilled market basket plus an estimate of a state minimum wage increase effective January 1, 2007. The estimate was based upon a methodology consistent with that applied in prior years when the state minimum wage increased.

⁵ No determination of the Medicaid shortfall could be made for 2006, since 2006 cost reports were unavailable in all but three states. The 2007 Medicaid shortfall is a projection based upon trending the most recently available cost reports to 2007 and comparing these trended costs to current rates.

⁶ The latest available audited cost data for New Hampshire were from 2004 while in Indiana, the state Medicaid contractor provided shortfall data only for the current year. Thus, a projected 2007 shortfall was determined for both of these states but a 2005 shortfall could not be determined for either due to missing data.

shortfall would be significantly greater. The charts on pages 14-17 reflect the per diem shortfall and the fiscal impact of the shortfall in each state by year.

FIGURE I
Shortfall per Medicaid Patient Day
All States in Each Year¹



¹ No determination of the Medicaid shortfall could be made for 2006, since 2006 cost reports were unavailable in all but three states. The 2007 Medicaid shortfall is a projection based upon trending the most recently available (2005) cost reports to 2007 and comparing these trended costs to current rates.

TABLE I
STATE-BY-STATE COMPARISON OF RATES AND COSTS

State	Rate 05	Cost 05	Difference 05
Arizona	\$ 133.33	\$ 148.56	\$ (15.23)
California	\$ 132.83	\$ 140.66	\$ (7.83)
Colorado	\$ 150.73	\$ 164.30	\$ (13.57)
Connecticut	\$ 183.05	\$ 200.63	\$ (17.58)
Delaware	\$ 205.61	\$ 227.75	\$ (22.14)
District of Columbia	\$ 176.05	\$ 194.69	\$ (18.64)
Florida	\$ 159.76	\$ 172.46	\$ (12.70)
Georgia	\$ 117.25	\$ 116.87	\$ 0.38
Hawaii	\$ 190.07	\$ 201.16	\$ (11.09)
Idaho	\$ 142.55	\$ 152.17	\$ (9.62)
Illinois	\$ 98.99	\$ 125.68	\$ (26.69)
Indiana	\$ -	\$ -	\$ -
Iowa	\$ 105.27	\$ 117.18	\$ (11.91)
Kansas	\$ 110.19	\$ 125.16	\$ (14.97)
Maine	\$ 160.62	\$ 171.51	\$ (10.89)
Maryland	\$ 177.43	\$ 186.35	\$ (8.92)
Massachusetts	\$ 173.94	\$ 191.56	\$ (17.62)
Michigan	\$ 161.13	\$ 166.86	\$ (5.73)
Minnesota	\$ 138.77	\$ 160.99	\$ (22.22)
Missouri	\$ 108.30	\$ 124.13	\$ (15.83)
Montana	\$ 143.80	\$ 141.55	\$ 2.25
Nebraska	\$ 130.13	\$ 139.15	\$ (9.02)
Nevada	\$ 164.41	\$ 168.41	\$ (4.00)
New Hampshire	\$ -	\$ -	\$ -
New Jersey	\$ 184.19	\$ 205.44	\$ (21.25)
New Mexico	\$ 140.51	\$ 157.49	\$ (16.98)
New York	\$ 199.65	\$ 220.89	\$ (21.24)
North Carolina	\$ 132.87	\$ 141.26	\$ (8.39)
North Dakota	\$ 142.26	\$ 144.90	\$ (2.64)
Ohio	\$ 161.89	\$ 166.33	\$ (4.44)
Oklahoma	\$ 102.80	\$ 109.95	\$ (7.15)
Oregon	\$ 145.54	\$ 163.06	\$ (17.52)
Pennsylvania	\$ 175.08	\$ 189.98	\$ (14.90)
South Carolina	\$ 123.89	\$ 131.10	\$ (7.21)
Tennessee	\$ 126.05	\$ 129.37	\$ (3.32)
Texas	\$ 94.67	\$ 107.56	\$ (12.89)
Utah	\$ 135.09	\$ 147.21	\$ (12.12)
Vermont	\$ 154.80	\$ 179.03	\$ (24.23)
Virginia	\$ 124.31	\$ 132.26	\$ (7.95)
Washington ¹	\$ 131.20	\$ 154.51	\$ (23.31)
West Virginia	\$ 168.02	\$ 169.76	\$ (1.74)
Wisconsin	\$ 130.78	\$ 154.32	\$ (23.54)

¹The shortfall for the state of Washington only represents a comparison of the operating cost to operating rate. Accurate allowable property cost data were not available so the comparison excludes property costs and the property component of the rate.

TABLE I
STATE-BY-STATE COMPARISON OF RATES AND COSTS
(Continued)

State	Rate 07	Projected Cost 07	Projected Difference 07
Arizona	\$ 136.83	\$ 152.23	\$ (15.40)
California	\$ 149.01	\$ 152.35	\$ (3.34)
Colorado	\$ 164.39	\$ 173.61	\$ (9.22)
Connecticut	\$ 211.89	\$ 224.29	\$ (12.40)
Delaware	\$ 217.38	\$ 239.59	\$ (22.21)
District of Columbia	\$ 185.76	\$ 204.85	\$ (19.09)
Florida	\$ 165.61	\$ 178.99	\$ (13.38)
Georgia	\$ 127.00	\$ 125.59	\$ 1.41
Hawaii	\$ 205.01	\$ 208.01	\$ (3.00)
Idaho	\$ 159.27	\$ 161.86	\$ (2.59)
Illinois	\$ 104.28	\$ 134.49	\$ (30.21)
Indiana	\$ 132.94	\$ 139.05	\$ (6.11)
Iowa	\$ 112.82	\$ 124.25	\$ (11.43)
Kansas	\$ 120.38	\$ 131.73	\$ (11.35)
Maine	\$ 165.35	\$ 181.21	\$ (15.86)
Maryland	\$ 188.83	\$ 197.71	\$ (8.88)
Massachusetts	\$ 180.19	\$ 200.04	\$ (19.85)
Michigan	\$ 178.23	\$ 178.63	\$ (0.40)
Minnesota	\$ 147.49	\$ 172.45	\$ (24.96)
Missouri	\$ 111.30	\$ 133.92	\$ (22.62)
Montana	\$ 152.58	\$ 153.41	\$ (0.83)
Nebraska	\$ 137.51	\$ 150.38	\$ (12.87)
Nevada	\$ 164.57	\$ 180.42	\$ (15.85)
New Hampshire	\$ 176.01	\$ 199.00	\$ (22.99)
New Jersey	\$ 187.17	\$ 215.81	\$ (28.64)
New Mexico	\$ 137.24	\$ 156.54	\$ (19.30)
New York ²	\$ 210.45	\$ 226.76	\$ (16.31)
North Carolina	\$ 134.78	\$ 151.08	\$ (16.30)
North Dakota	\$ 150.81	\$ 151.76	\$ (0.95)
Ohio	\$ 162.22	\$ 177.37	\$ (15.15)
Oklahoma	\$ 116.84	\$ 119.92	\$ (3.08)
Oregon	\$ 179.30	\$ 180.20	\$ (0.90)
Pennsylvania	\$ 189.17	\$ 201.08	\$ (11.91)
South Carolina	\$ 136.72	\$ 140.43	\$ (3.71)
Tennessee	\$ 135.01	\$ 136.18	\$ (1.17)
Texas	\$ 105.80	\$ 114.46	\$ (8.66)
Utah	\$ 143.26	\$ 156.35	\$ (13.09)
Vermont	\$ 166.61	\$ 190.93	\$ (24.32)
Virginia	\$ 128.40	\$ 138.05	\$ (9.65)
Washington ¹	\$ 140.10	\$ 160.81	\$ (20.71)
West Virginia	\$ 174.36	\$ 176.67	\$ (2.31)
Wisconsin	\$ 135.60	\$ 162.89	\$ (27.29)

¹ The shortfall for the state of Washington only represents a comparison of the operating cost to operating rate. Accurate allowable property cost data were not available so the comparison excludes property costs and the property component of the rate.

² Prior to 2006 in New York State, pharmaceuticals were reimbursed through the Medicaid daily rate. Beginning in 2006, under the Medicare Modernization Act, the state is no longer responsible for the majority of drug costs for dual-eligibles and as such, the Medicaid rates and costs were adjusted to reflect this change.

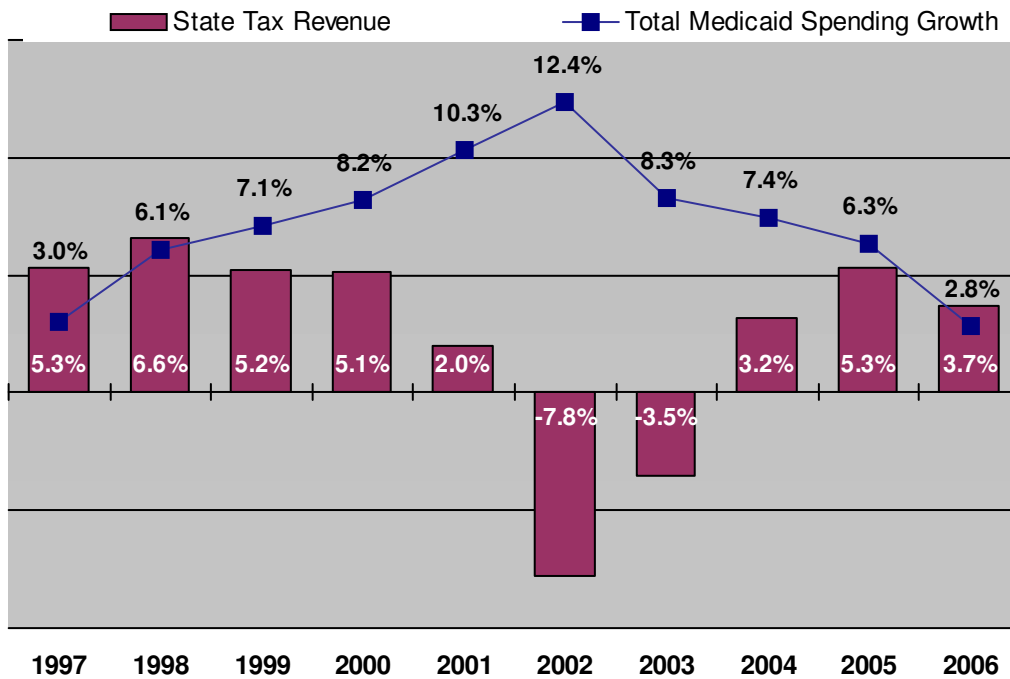
³ The significant reduction in the shortfall in Oregon from 2005 to 2007 was due to an increase in provider taxes, which resulted in increased rates and rates being set at a higher percentile of cost.

⁴ The significant increase in the shortfall from 2005 to 2007 in Nevada, North Carolina and Ohio was due to minimal rate increases in these states during that time period.

NURSING HOME REIMBURSEMENT TRENDS

Overall, the economic performance of states continues to improve. As shown in Figure II, FY 2006 state revenue growth exceeded total Medicaid spending growth for the first time since 1998. Total Medicaid spending growth slowed for the fourth consecutive year to an estimated 2.8% in 2006.

FIGURE II
State Tax Revenue and Total Medicaid Spending Growth, 1997 – 2006



NOTE: State Tax Revenue data are adjusted for inflation and legislative changes. Preliminary estimates for revenues and Medicaid spending for 2006.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2006 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

FY 2007 was also a year of stable financial conditions for most states. According to the June 2007 “Fiscal Survey of States,” only three states were forced to reduce their enacted budgets by an aggregate \$170 million in fiscal 2007, and only five reported negative expenditure growth. By comparison, in FY 2003, 21 states enacted negative revenue growth budgets with 37 states forced to make reductions to enacted budgets in FY 2002 and FY 2003, totaling \$12.6 and \$11.7 billion, respectively.

The improved budget stability among states from FY 2003 to FY 2007 has helped reduce the nursing home Medicaid shortfall from \$14.60 to \$13.15 during this timeframe. As a percentage of allowable costs, Medicaid reimbursement has improved from 89.9% to 92.2%.

THE ROLE OF PROVIDER TAXES, INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES IN FINANCIAL STABILITY

The reduction in the Medicaid shortfall between 2003 and 2007 can be as much attributable to implementation of provider tax programs as to improved economic conditions in the states. Between FY 2004 and FY 2007, many states implemented or expanded provider tax programs and used these proceeds and corresponding federal matching funds to increase Medicaid rates to nursing homes. Prior to FY 2004, 20 states assessed provider taxes on nursing homes. In FY 2007, 32 states and the District of Columbia have implemented nursing home tax programs. Overall, provider taxes on nursing homes generate nearly \$3.8 billion in matching federal funds, and in the states affected, are used to reimburse an average of \$14 per patient day in allowable Medicaid nursing home costs.

While no new nursing home provider tax programs were implemented in 2007 (the Maryland legislature passed a tax program in 2007 but it has not yet been implemented), at least 10 states increased their tax assessments in the last two years to support their rate increases. One state (Washington) actually reduced their tax rate while another (New Mexico) repealed their tax in 2006.

States are limited in the amount of provider taxes that can be assessed and matched by federal funds. The current limitation, 6% of annual patient revenues received by providers, will decrease to 5.5% effective January 1, 2008. We estimate that in FY 2008, 19 of the 32 states and the District of Columbia will be above or very close to the 5.5% limit, and may have to adjust their tax rates accordingly, which could negatively impact rates. One state (Nevada) has published a draft schedule of rates effective January 1, 2008 that reflects a decrease from those that were effective July 1, 2007.

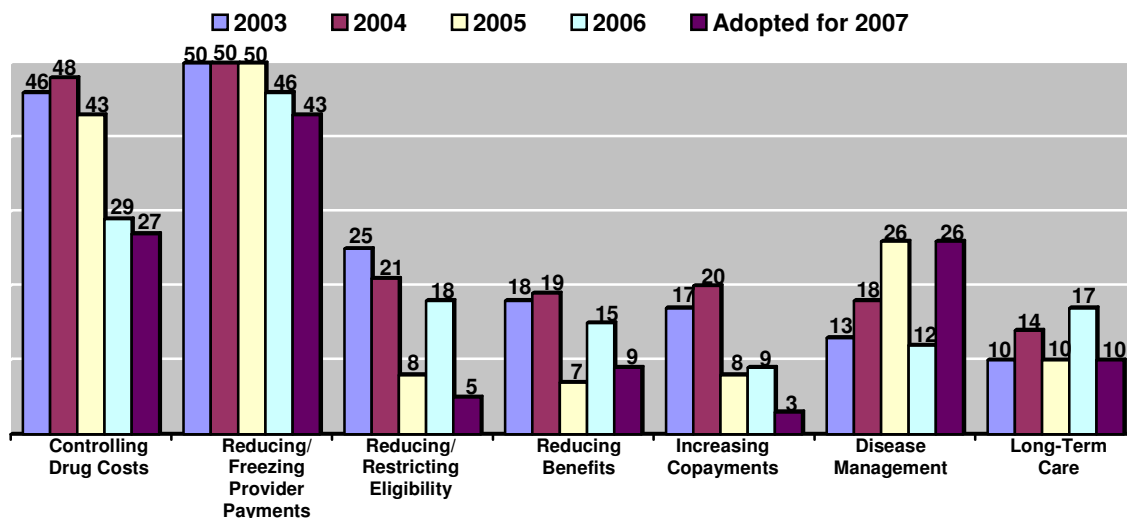
As to Intergovernmental Transfers and Certified Public Expenditures, CMS has issued a proposed rule, which in effect, requires the federal dollars generated from these programs to remain with the public facilities that are incurring Medicaid shortfalls. The federal dollars can no longer be used to help subsidize state budgets or to increase rates to non-public providers. New limits also reduce the federal dollars that can be generated from these programs. The impact of this proposed rule on future Medicaid rates is difficult to predict but will certainly increase the percentage of total Medicaid expenditures financed with state funds.

THE ROLE OF WAIVERS AND REBALANCING IN LIMITING GROWTH IN MEDICAID NURSING HOME EXPENDITURES

Even with improving economies, states are still implementing Medicaid reform strategies to reduce eligibility and benefits, increase co-payments, reduce payments to providers and better manage their limited resources. Some are utilizing managed care approaches through Section 1115 and Section 1915(b)/(c) waivers for delivery of long term care services, while others utilize service prioritization strategies.⁷ According to the Kaiser Commission on Medicaid and the Uninsured, over the last few years, every state has implemented policies to freeze or reduce provider payments and to control prescription drug spending. Figure III on page 9 reflects the cost containment strategies states have taken since FY 2003 and the number of states adopting each approach by year.

⁷ Section 1115 of the Social Security Act provides a mechanism to waive statutory and regulatory provisions of health and welfare programs including Medicaid. States can obtain comprehensive waivers to make very broad changes in eligibility, benefits or cost sharing. Section 1915(b) waivers allow states to operate Medicaid mandatory managed care programs, while Section 1915(c) waivers establish federal requirements for states choosing to provide HCBS waiver programs for individuals who would otherwise qualify for institutional care.

FIGURE III
States Undertaking New Medicaid Cost Containment Strategies FY 2003 – FY 2007



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, October 2005, October 2006.

In addition, all the states are rebalancing their limited resources by redirecting more funds to home and community-based programs. Nowhere is this better reflected than in CMS' Money Follows the Person Rebalancing Demonstration that will provide \$1.75 billion in funding awards to eligible states to increase the use of home and community-based long-term care services. To date, \$1.4 billion has been awarded to 31 states with a goal of transitioning over 16,000 elderly from institutional to community settings over the five-year demonstration period. To receive the awards, states must fund their state share of these transition costs, albeit at a lower percentage (higher federal match rate) for the first year after the individual moves into the community. After the initial year, the state receives no further enhanced federal match and must continue to provide community services as long as the individual needs such services and is Medicaid eligible.

While this demonstration likely has minimal implications on state budgets in FY 2007 and into FY 2008 as states develop their plans and infrastructure for transition, the state financing requirements for this program in subsequent years will be significant, creating a greater strain on limited state resources. While it can be argued that savings may be generated from slowing the

growth of nursing home occupancy, the savings may not be fully realized based upon a combination of the aging demographics, an increase in the quantity and intensity of services provided, and expansion of covered services. In any case, it is another service component of long term care that must be funded by the participating states, which may diminish the dollars available for nursing home rate increases.

THE ROLE OF MEDICARE IN SUBSIDIZING MEDICAID SHORTFALLS

Medicare continues to play an important role in the cross-subsidization of Medicaid deficits. According to the Medicare Payment Advisory Commission, the average margin on Medicare payment to nursing homes in 2005 is 13%,⁸ while our analysis indicates a 9.2% shortfall on Medicaid payment for that year (weighted average 2005 shortfall of \$13.43 divided by weighted average Medicaid rate of \$145.44). The weighted average 2005 margin from the two government funded programs combined is a negative 2.5% (see Figure IV).⁹

**Figure IV
Combined Medicare/Medicaid Shortfall for 2005**

Payer	2005 Average Rates	Days in Millions	Revenues In Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	\$ 336.47	64.4	\$ 21.67	13.00%	\$ 2.82
Medicaid	\$ 145.44	343.0	\$ 49.89	(9.23%)	\$ (4.60)
					\$ (1.78)
Net Medicare/Medicaid Shortfall as a Percentage of Revenue					<u>(2.5%)</u>

Sources: Medicare Rates and Days Computed by AHCA Reimbursement and Research Department using CMS SAF (standard analytic file) LDS (limited data set) 100% SNF claims data for 2005. Medicare margin percentage derived from June 2007 Medicare Payment Advisory Commission Report to Congress. Medicaid rates, days and margins derived from this Shortfall Report.

⁸ June 2007 Medicare Payment Advisory Commission Report to Congress.

⁹ Together Medicare and Medicaid represent approximately 80 percent of nursing facility residents. If other payor sources were included (e.g., private pay, private insurance, managed care, etc.), overall margins in 2005 would likely have been close to zero or slightly positive.

This simple analysis demonstrates that nursing homes maintain their ability to operate by subsidizing their Medicaid deficits with the margins attained on the Medicare program. With such an equilibrium created by the combination of these two payers, any increase in Medicaid deficits or decrease in Medicare margins could have serious adverse financial implications for the industry.

NURSING HOME REIMBURSEMENT OUTLOOK FOR 2008

According to the June 2007 “Fiscal Survey of States,” FY 2007 was a year of stable financial condition for most states. While most states expect a steady fiscal 2008 with reasonable revenue growth, a handful of states are already seeing some slowing of their revenues especially in the area of sales and use taxes. The Center on Budget and Policy Priorities (CBPP) identifies at least nine states with projected budget gaps in FY 2008, with 24 in total facing potential budget trouble. According to CBPP, state budgets currently appear strong due in significant part to the up tick in state revenue collections that occurred from 2004 to 2006 as states emerged from the last recession.

Even with uncertainties regarding state economies, the Medicaid rate trends for FY 2008 for nursing homes appear relatively positive. Data from state industry experts suggest that FY 2008 rates will increase at or slightly above the Market Basket Index in 19 of 24 states responding. However, past experience indicates that if budget gaps exist or the federal government further curtails programs such as Provider Taxes, Intergovernmental Transfers and Certified Public Expenditures, states will likely freeze or reduce provider rates. Predictability and stability no longer exist in Medicaid rate setting.

SUMMARY

Due to a combination of robust state economies and other revenue sources such as provider taxes, the average Medicaid payment shortfall for nursing home providers is projected to decline between 2005 and 2007 to about \$13 per Medicaid patient day. Nevertheless, un-reimbursed Medicaid allowable costs are projected to exceed \$4.4 billion, and providers must continue to

substantially rely on Medicare prospective payment in an attempt to break even from government funded programs. Any major slowdown in state economies or changes in federal policies or interpretations regarding federal revenue enhancement programs could easily reverse the positive trends of the past few years. In addition, as states continue to rebalance and build infrastructure to expand home and community-based services, it is likely that more Medicaid-eligible consumers will take advantage of such services. This will create added pressure on state budgets and may further constrain future rate increases for nursing homes.

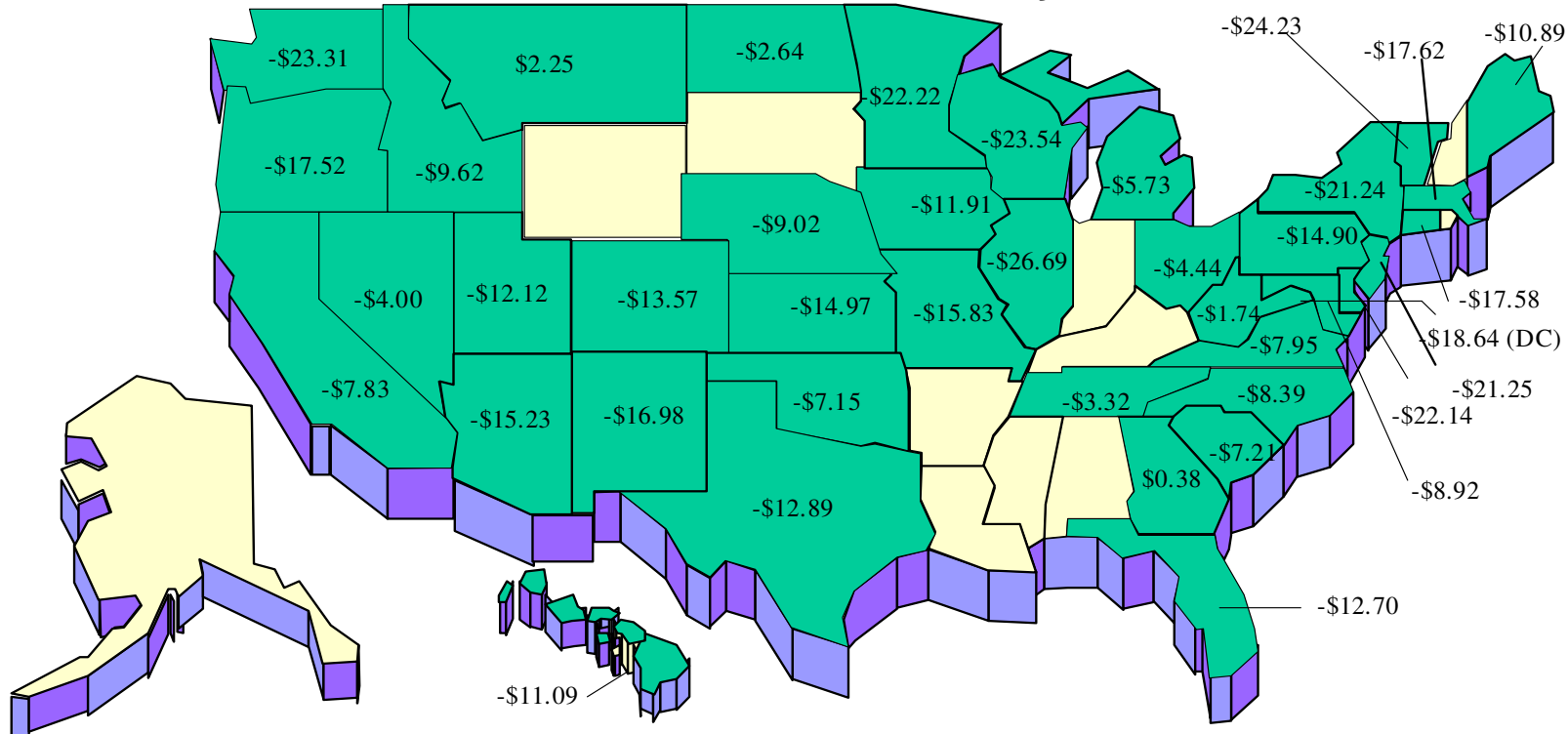
Charts

- Chart 1 Average Medicaid Shortfall Per Patient Day and Average Disparity by State Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs**
- Chart 2 Disparity By State Between Total Medicaid Revenue and Total Medicaid Allowable Costs**

CHART 1

**In 2005, on Average, the Shortfall in Medicaid Reimbursement
Was \$13.43 Per Medicaid Patient Day**

**Average Disparity By State Between Medicaid Rates and
Allowable Medicaid Per Patient Day Costs**



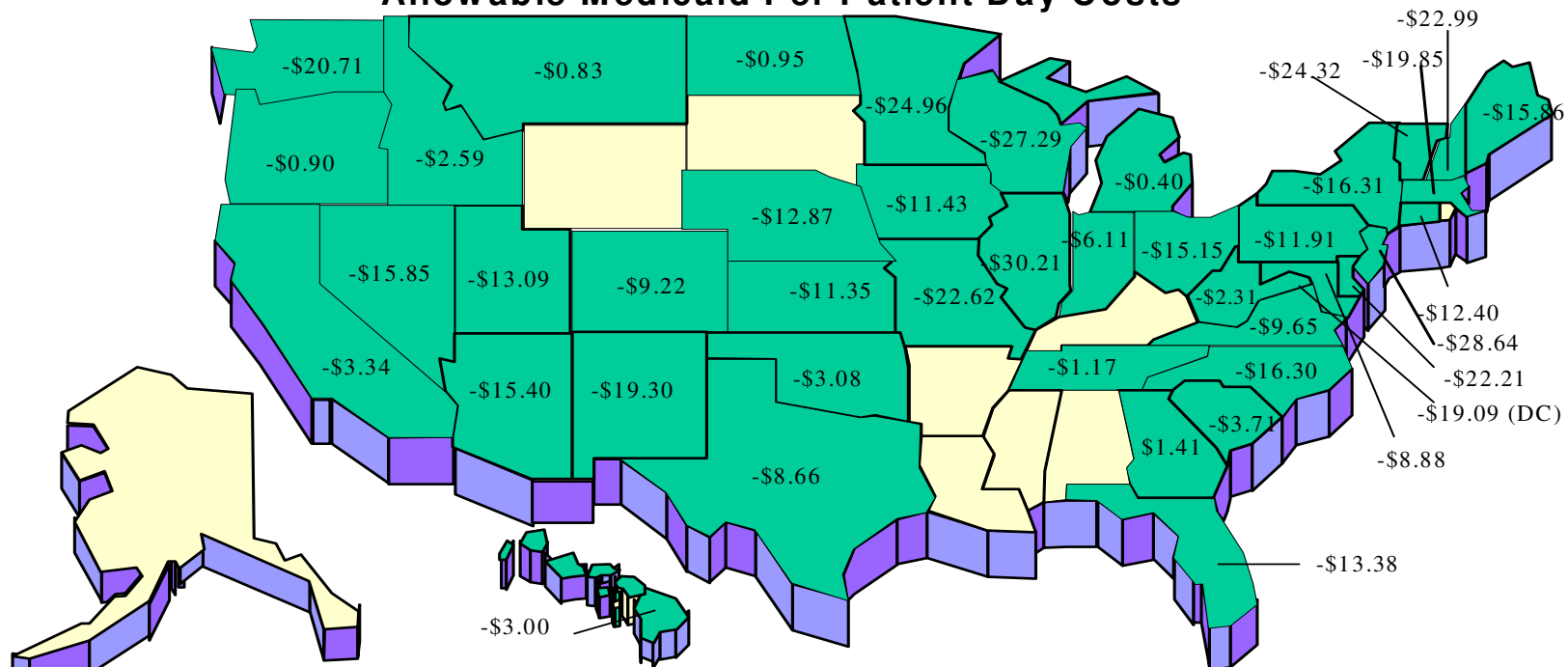
Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP and Eljay, LLC. (See Appendix 1.) The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.



CHART 1

**The Projected Average 2007 Shortfall in Medicaid Reimbursement
Is \$13.15 Per Medicaid Patient Day**

**Average Disparity By State Between Medicaid Rates and
Allowable Medicaid Per Patient Day Costs**

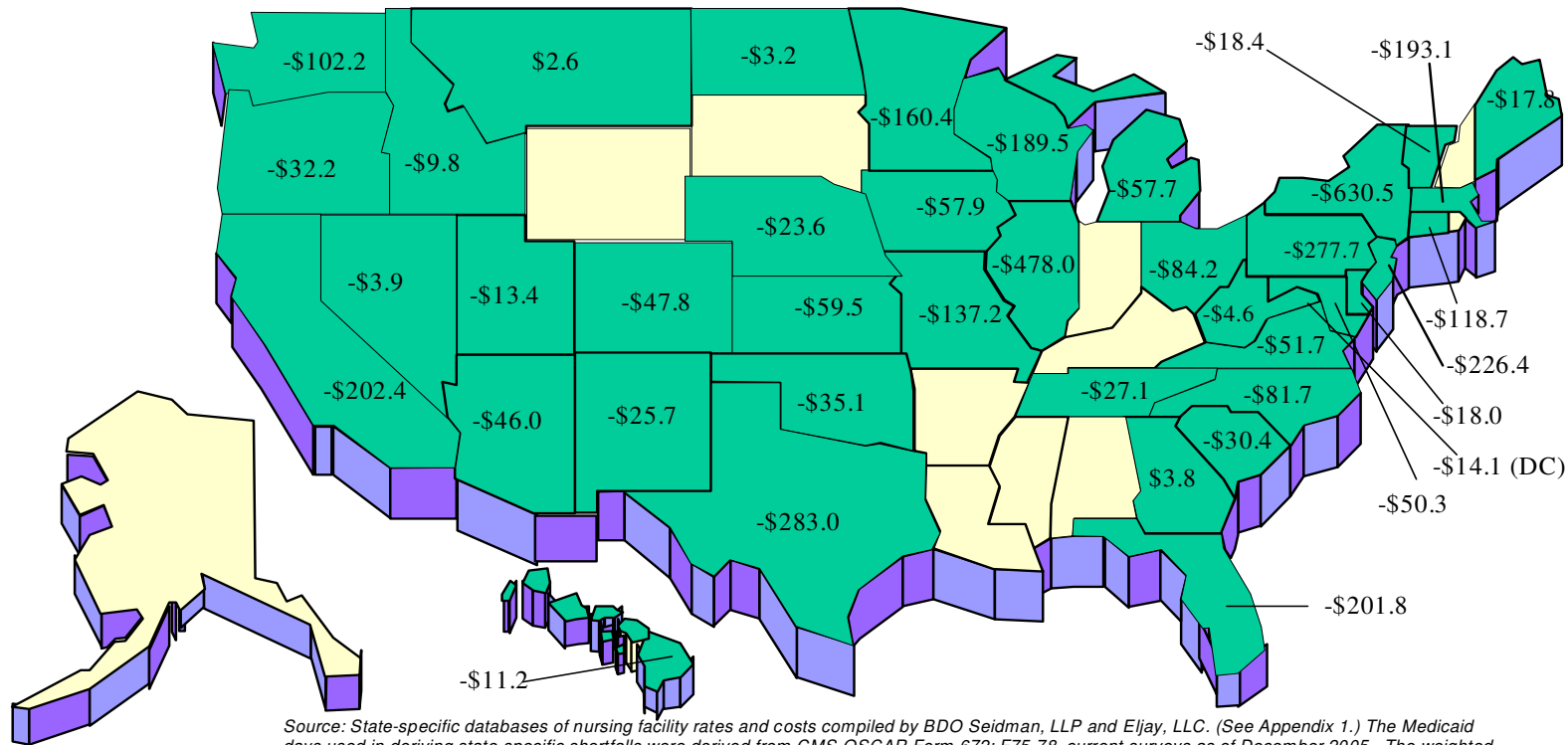


Source: State-specific databases of nursing facility rates and the most recent costs projected to the current rate period. (See Appendix 1.) The amounts represent the difference between Medicaid rates and projected allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and projected costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.



2005 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

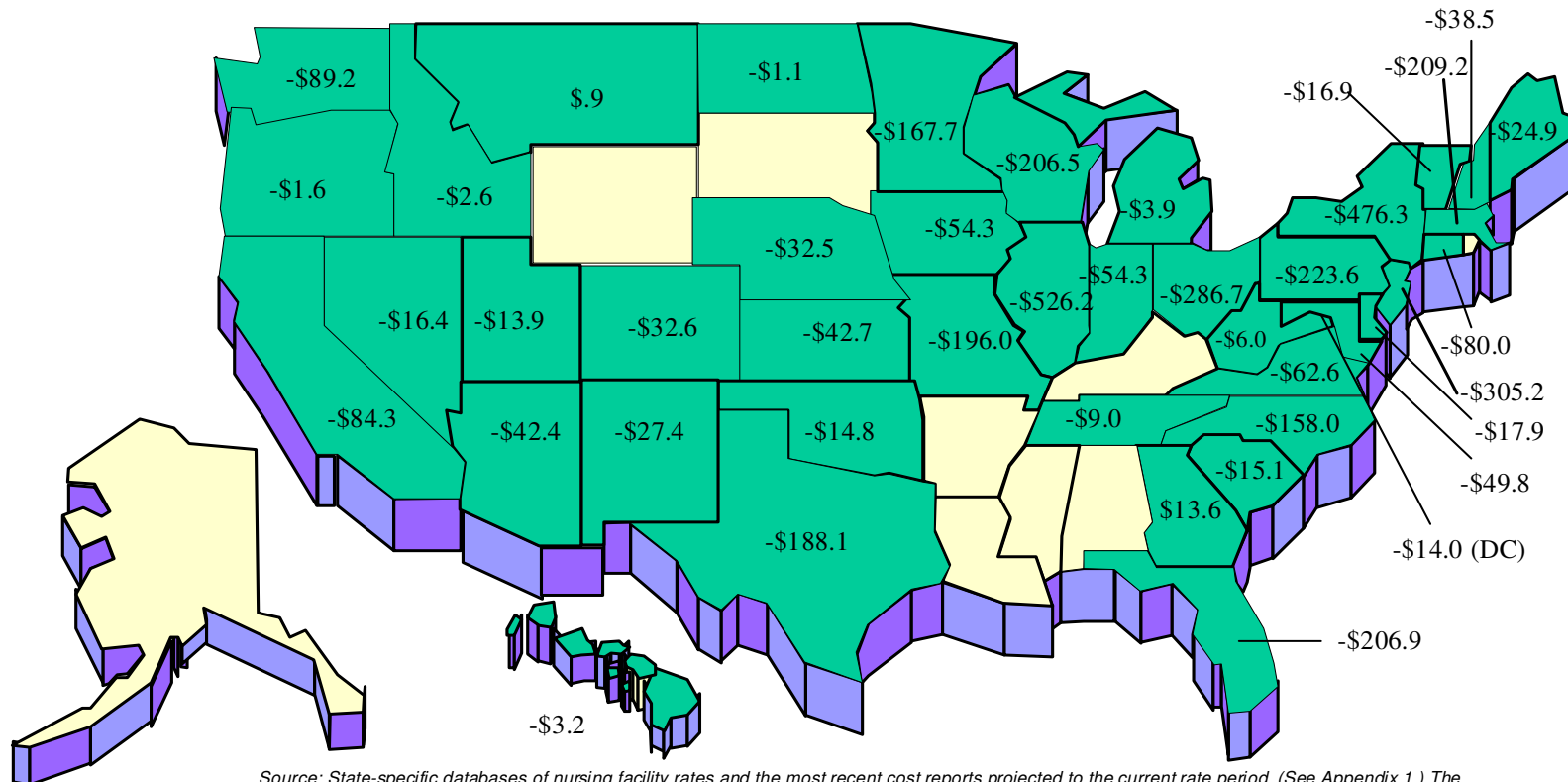
\$4.6 Billion Medicaid Funding Shortfall Nationwide



Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP and Eljay, LLC. (See Appendix 1.) The Medicaid days used in deriving state-specific shortfalls were derived from CMS-OSCAR Form 672: F75-78, current surveys as of December 2005. The weighted average shortfall for the 39 states (plus the District of Columbia) reporting exceeded \$4.0 billion dollars, based upon 299 million Medicaid days. Extrapolating this shortfall to 343 million Medicaid days nationwide (per CMS-OSCAR Data) results in a \$4.6 billion national shortfall.



**Projected 2007 Disparity By State Between Total Medicaid Revenue
 and Total Allowable Medicaid Costs (In Millions)**
\$4.4 Billion Medicaid Funding Shortfall Nationwide



Source: State-specific databases of nursing facility rates and the most recent cost reports projected to the current rate period. (See Appendix 1.) The Medicaid days used in deriving state-specific shortfalls were derived from CMS-OSCAR Form 672: F75-78, current surveys as of December 2005. The weighted average shortfall for the 41 states (plus the District of Columbia) reporting was almost \$4.0 billion dollars, based upon 303 million Medicaid days. Extrapolating this shortfall to 335 million Medicaid days nationwide (per CMS-OSCAR Data) results in a \$4.4 billion national shortfall.



Appendix I

Project Approach and Methodology

PROJECT APPROACH AND METHODOLOGY

The American Health Care Association initially surveyed its state affiliates as to the availability of a database of state-specific Medicaid rate and allowable cost information. Those that responded in the affirmative were asked to complete “data collection spreadsheets” reflecting the Medicaid rates and allowable costs for each provider based upon the provider’s fiscal or calendar years ending in 2005. In addition, the state affiliates were requested to provide current Medicaid rates by provider to allow comparisons, not only between allowable costs and Medicaid rates in 2005, but between current rates and 2005 costs trended to the same time period. Sample data collection spreadsheets are included as Appendix IV.

BDO and Eljay were engaged to assist in this process by:

1. Developing the data collection spreadsheets;
2. Instructing and guiding state affiliates through the process;
3. Reviewing the results for reasonableness and compliance with document instructions;
4. Contacting other sources such as state agencies, their consultants and independent accounting firms to obtain the data in those states where the data was readily available, but the state affiliate did not have it;
5. Developing the comparisons between current Medicaid rates and the most recent cost reports trended to the same time frame; and
6. Compiling the results into a report.

In almost all cases, the state affiliates indicated that the data were derived from a database of Medicaid rates and allowable costs obtained from their state agencies. Allowable costs include only those costs recognized by the state agency as directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of facilities, and out-of-state travel. The cost database reflected costs that have been audited or desk-reviewed by the Medicaid state

agency in 85% of the states in 2005. BDO and Eljay did not replicate the calculations nor trace individual facility cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 2005 were derived for 39 states plus the District of Columbia, representing over 87% of the Medicaid patient days in the country in both years. Current Medicaid rates by provider were obtained from 41 states and the District of Columbia allowing us to determine an estimated 2007 shortfall for these states that represent 91% of Medicaid days nationwide.¹⁰ The remaining states not reflected in the comparisons indicated that the data was not readily available. However, as can be seen by the charts on pages 14-17, these states reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide. The comparisons include all of the states representing the largest Medicaid populations, including California, Florida, Illinois, Massachusetts, New York, Ohio, Pennsylvania and Texas. Based upon the high percentage of nationwide Medicaid patient days represented by the states, it is likely that the overall results would not materially change had all states been represented.

¹⁰ The latest available audited cost data for New Hampshire were from 2004 while in Indiana, the state Medicaid contractor provided shortfall data only for the current year. Thus, a projected 2007 shortfall was determined for both of these states but a 2005 shortfall could not be determined for either due to missing data.

Appendix II

Calculation of 2005 and Projected 2007 Weighted Average Medicaid Shortfall

State-by-State Comparison

Calculation of 2005 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	\$ 133.33	\$ 148.56	\$ (15.23)	3,020,010	\$ 402,657,933	\$ 448,652,686	\$ (45,994,752)
California	\$ 132.83	\$ 140.66	\$ (7.83)	25,855,140	\$ 3,434,338,246	\$ 3,636,783,992	\$ (202,445,746)
Colorado	\$ 150.73	\$ 164.30	\$ (13.57)	3,522,980	\$ 531,018,775	\$ 578,825,614	\$ (47,806,839)
Connecticut	\$ 183.05	\$ 200.63	\$ (17.58)	6,749,215	\$ 1,235,443,806	\$ 1,354,095,005	\$ (118,651,200)
Delaware	\$ 205.61	\$ 227.75	\$ (22.14)	812,490	\$ 167,056,069	\$ 185,044,598	\$ (17,988,529)
District of Columbia	\$ 176.05	\$ 194.69	\$ (18.64)	758,105	\$ 133,464,385	\$ 147,595,462	\$ (14,131,077)
Florida	\$ 159.76	\$ 172.46	\$ (12.70)	15,892,830	\$ 2,539,038,521	\$ 2,740,877,462	\$ (201,838,941)
Georgia	\$ 117.25	\$ 116.87	\$ 0.38	10,020,710	\$ 1,174,928,248	\$ 1,171,120,378	\$ 3,807,870
Hawaii	\$ 190.07	\$ 201.16	\$ (11.09)	1,005,575	\$ 191,129,640	\$ 202,281,467	\$ (11,151,827)
Idaho	\$ 142.55	\$ 152.17	\$ (9.62)	1,019,810	\$ 145,373,916	\$ 155,184,488	\$ (9,810,572)
Illinois	\$ 98.99	\$ 125.68	\$ (26.69)	17,910,550	\$ 1,772,965,345	\$ 2,250,997,924	\$ (478,032,580)
Iowa	\$ 105.27	\$ 117.18	\$ (11.91)	4,862,895	\$ 511,916,957	\$ 569,834,036	\$ (57,917,079)
Kansas	\$ 110.19	\$ 125.16	\$ (14.97)	3,973,755	\$ 437,868,063	\$ 497,355,176	\$ (59,487,112)
Maine	\$ 160.62	\$ 171.51	\$ (10.89)	1,635,200	\$ 262,645,824	\$ 280,453,152	\$ (17,807,328)
Maryland	\$ 177.43	\$ 186.35	\$ (8.92)	5,642,535	\$ 1,001,154,985	\$ 1,051,486,397	\$ (50,331,412)
Massachusetts	\$ 173.94	\$ 191.56	\$ (17.62)	10,960,950	\$ 1,906,547,643	\$ 2,099,679,582	\$ (193,131,939)
Michigan	\$ 161.13	\$ 166.86	\$ (5.73)	10,065,605	\$ 1,621,870,934	\$ 1,679,546,850	\$ (57,675,917)
Minnesota	\$ 138.77	\$ 160.99	\$ (22.22)	7,217,510	\$ 1,001,573,863	\$ 1,161,946,935	\$ (160,373,072)
Missouri	\$ 108.30	\$ 124.13	\$ (15.83)	8,667,290	\$ 938,667,507	\$ 1,075,870,708	\$ (137,203,201)
Montana	\$ 143.80	\$ 141.55	\$ 2.25	1,145,370	\$ 164,704,206	\$ 162,127,124	\$ 2,577,083
Nebraska	\$ 130.13	\$ 139.15	\$ (9.02)	2,614,130	\$ 340,176,737	\$ 363,756,190	\$ (23,579,453)
Nevada	\$ 164.41	\$ 168.41	\$ (4.00)	976,740	\$ 160,585,823	\$ 164,492,783	\$ (3,906,960)
New Jersey	\$ 184.19	\$ 205.44	\$ (21.25)	10,652,525	\$ 1,962,088,580	\$ 2,188,454,736	\$ (226,366,156)
New Mexico	\$ 140.51	\$ 157.49	\$ (16.98)	1,515,480	\$ 212,940,095	\$ 238,672,945	\$ (25,732,850)
New York	\$ 199.65	\$ 220.89	\$ (21.24)	29,684,720	\$ 5,926,554,348	\$ 6,557,057,801	\$ (630,503,453)
North Carolina	\$ 132.87	\$ 141.26	\$ (8.39)	9,739,660	\$ 1,294,108,624	\$ 1,375,824,372	\$ (81,715,747)
North Dakota	\$ 142.26	\$ 144.90	\$ (2.64)	1,215,815	\$ 172,961,842	\$ 176,171,594	\$ (3,209,752)
Ohio	\$ 161.89	\$ 166.33	\$ (4.44)	18,965,765	\$ 3,070,367,696	\$ 3,154,575,692	\$ (84,207,997)
Oklahoma	\$ 102.80	\$ 109.95	\$ (7.15)	4,913,265	\$ 505,083,642	\$ 540,213,487	\$ (35,129,845)
Oregon	\$ 145.54	\$ 163.06	\$ (17.52)	1,839,235	\$ 267,682,262	\$ 299,905,659	\$ (32,223,397)
Pennsylvania	\$ 175.08	\$ 189.98	\$ (14.90)	18,635,075	\$ 3,262,628,931	\$ 3,540,291,549	\$ (277,662,618)
South Carolina	\$ 123.89	\$ 131.10	\$ (7.21)	4,211,735	\$ 521,791,849	\$ 552,158,459	\$ (30,366,609)
Tennessee	\$ 126.05	\$ 129.37	\$ (3.32)	8,173,810	\$ 1,030,308,751	\$ 1,057,445,800	\$ (27,137,049)
Texas	\$ 94.67	\$ 107.56	\$ (12.89)	21,955,845	\$ 2,078,559,846	\$ 2,361,570,688	\$ (283,010,842)
Utah	\$ 135.09	\$ 147.21	\$ (12.12)	1,107,410	\$ 149,600,017	\$ 163,021,826	\$ (13,421,809)
Vermont	\$ 154.80	\$ 179.03	\$ (24.23)	759,565	\$ 117,580,662	\$ 135,984,922	\$ (18,404,260)
Virginia	\$ 124.31	\$ 132.26	\$ (7.95)	6,502,475	\$ 808,322,667	\$ 860,017,344	\$ (51,694,676)
Washington	\$ 131.20	\$ 154.51	\$ (23.31)	4,385,110	\$ 575,326,432	\$ 677,543,346	\$ (102,216,914)
West Virginia	\$ 168.02	\$ 169.76	\$ (1.74)	2,618,875	\$ 440,023,378	\$ 444,580,220	\$ (4,556,843)
Wisconsin	\$ 130.78	\$ 154.32	\$ (23.54)	8,051,170	\$ 1,052,932,013	\$ 1,242,456,554	\$ (189,524,542)

TOTALS 299,256,930 \$ 43,523,989,059 \$ 47,543,955,000 \$ (4,019,965,942)

Weighted Averages \$ 145.44 \$ 158.87 \$ (13.43)

Shortfall extrapolated to all 50 states \$ (4,607,583,231)

Total States plus the District of Columbia 40

Percentage of Days 87.25%

Calculation of Projected 2007 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	\$ 136.83	\$ 152.23	\$ (15.40)	2,751,941	\$ 376,548,150	\$ 418,928,049	\$ (42,379,899)
California	\$ 149.01	\$ 152.35	\$ (3.34)	25,233,726	\$ 3,760,077,518	\$ 3,844,358,163	\$ (84,280,645)
Colorado	\$ 164.39	\$ 173.61	\$ (9.22)	3,537,551	\$ 581,537,974	\$ 614,154,192	\$ (32,616,218)
Connecticut	\$ 211.89	\$ 224.29	\$ (12.40)	6,455,661	\$ 1,367,889,917	\$ 1,447,940,108	\$ (80,050,191)
Delaware	\$ 217.38	\$ 239.59	\$ (22.21)	804,278	\$ 174,834,010	\$ 192,697,030	\$ (17,863,020)
District of Columbia	\$ 185.76	\$ 204.85	\$ (19.09)	735,897	\$ 136,700,203	\$ 150,748,474	\$ (14,048,271)
Florida	\$ 165.61	\$ 178.99	\$ (13.38)	15,462,697	\$ 2,560,777,227	\$ 2,767,668,111	\$ (206,890,884)
Georgia	\$ 127.00	\$ 125.59	\$ 1.41	9,629,407	\$ 1,222,934,719	\$ 1,209,357,255	\$ 13,577,464
Hawaii	\$ 205.01	\$ 208.01	\$ (3.00)	1,062,041	\$ 217,729,057	\$ 220,915,181	\$ (3,186,123)
Idaho	\$ 159.27	\$ 161.86	\$ (2.59)	992,853	\$ 158,131,735	\$ 160,703,225	\$ (2,571,490)
Illinois	\$ 104.28	\$ 134.49	\$ (30.21)	17,416,515	\$ 1,816,194,227	\$ 2,342,347,157	\$ (526,152,931)
Indiana	\$ 132.94	\$ 139.05	\$ (6.11)	8,893,098	\$ 1,182,248,513	\$ 1,236,585,345	\$ (54,336,832)
Iowa	\$ 112.82	\$ 124.25	\$ (11.43)	4,751,459	\$ 536,059,574	\$ 590,368,747	\$ (54,309,173)
Kansas	\$ 120.38	\$ 131.73	\$ (11.35)	3,760,536	\$ 452,693,298	\$ 495,375,379	\$ (42,682,081)
Maine	\$ 165.35	\$ 181.21	\$ (15.86)	1,568,908	\$ 259,419,020	\$ 284,301,909	\$ (24,882,889)
Maryland	\$ 188.83	\$ 197.71	\$ (8.88)	5,611,397	\$ 1,059,600,018	\$ 1,109,429,220	\$ (49,829,202)
Massachusetts	\$ 180.19	\$ 200.04	\$ (19.85)	10,541,147	\$ 1,899,409,336	\$ 2,108,651,111	\$ (209,241,774)
Michigan	\$ 178.23	\$ 178.63	\$ (0.40)	9,789,252	\$ 1,744,738,354	\$ 1,748,654,055	\$ (3,915,701)
Minnesota	\$ 147.49	\$ 172.45	\$ (24.96)	6,719,320	\$ 991,032,503	\$ 1,158,746,730	\$ (167,714,227)
Missouri	\$ 111.30	\$ 133.92	\$ (22.62)	8,663,019	\$ 964,193,973	\$ 1,160,151,454	\$ (195,957,481)
Montana	\$ 152.58	\$ 153.41	\$ (0.83)	1,139,074	\$ 173,799,935	\$ 174,745,366	\$ (945,432)
Nebraska	\$ 137.51	\$ 150.38	\$ (12.87)	2,526,459	\$ 347,413,312	\$ 379,928,833	\$ (32,515,521)
Nevada	\$ 164.57	\$ 180.42	\$ (15.85)	1,034,635	\$ 170,269,927	\$ 186,668,896	\$ (16,398,969)
New Hampshire	\$ 176.01	\$ 199.00	\$ (22.99)	1,676,613	\$ 295,100,712	\$ 333,646,052	\$ (38,545,340)
New Jersey	\$ 187.17	\$ 215.81	\$ (28.64)	10,655,563	\$ 1,994,401,723	\$ 2,299,577,047	\$ (305,175,324)
New Mexico	\$ 137.24	\$ 156.54	\$ (19.30)	1,419,614	\$ 194,827,864	\$ 222,226,419	\$ (27,398,556)
New York	\$ 210.45	\$ 226.76	\$ (16.31)	29,200,609	\$ 6,145,268,063	\$ 6,621,529,988	\$ (476,261,925)
North Carolina	\$ 134.78	\$ 151.08	\$ (16.30)	9,690,262	\$ 1,306,053,475	\$ 1,464,004,741	\$ (157,951,266)
North Dakota	\$ 150.81	\$ 151.76	\$ (0.95)	1,203,802	\$ 181,545,427	\$ 182,689,039	\$ (1,143,612)
Ohio	\$ 162.22	\$ 177.37	\$ (15.15)	18,921,670	\$ 3,069,473,299	\$ 3,356,136,598	\$ (286,663,300)
Oklahoma	\$ 116.84	\$ 119.92	\$ (3.08)	4,810,153	\$ 562,018,222	\$ 576,833,492	\$ (14,815,270)
Oregon	\$ 179.30	\$ 180.20	\$ (0.90)	1,747,465	\$ 313,320,557	\$ 314,893,276	\$ (1,572,719)
Pennsylvania	\$ 189.17	\$ 201.08	\$ (11.91)	18,771,636	\$ 3,551,030,292	\$ 3,774,600,471	\$ (223,570,179)
South Carolina	\$ 136.72	\$ 140.43	\$ (3.71)	4,073,148	\$ 556,880,850	\$ 571,992,230	\$ (15,111,381)
Tennessee	\$ 135.01	\$ 136.18	\$ (1.17)	7,668,081	\$ 1,035,267,579	\$ 1,044,239,234	\$ (8,971,654)
Texas	\$ 105.80	\$ 114.46	\$ (8.66)	21,716,374	\$ 2,297,592,321	\$ 2,485,656,116	\$ (188,063,795)
Utah	\$ 143.26	\$ 156.35	\$ (13.09)	1,061,245	\$ 152,033,892	\$ 165,925,583	\$ (13,891,691)
Vermont	\$ 166.61	\$ 190.93	\$ (24.32)	695,872	\$ 115,939,235	\$ 132,862,843	\$ (16,923,607)
Virginia	\$ 128.40	\$ 138.05	\$ (9.65)	6,488,798	\$ 833,161,657	\$ 895,778,557	\$ (62,616,900)
Washington	\$ 140.10	\$ 160.81	\$ (20.71)	4,306,426	\$ 603,330,274	\$ 692,516,355	\$ (89,186,081)
West Virginia	\$ 174.36	\$ 176.67	\$ (2.31)	2,617,232	\$ 456,340,587	\$ 462,386,393	\$ (6,045,806)
Wisconsin	\$ 135.60	\$ 162.89	\$ (27.29)	7,567,665	\$ 1,026,175,374	\$ 1,232,696,952	\$ (206,521,578)
TOTALS				303,373,099	\$ 46,843,993,904	\$ 50,833,615,377	\$ (3,989,621,474)
Weighted Averages					\$ 154.41	\$ 167.56	\$ (13.15)
Shortfall extrapolated to all 50 states							\$ (4,408,398,495)
Total States plus the District of Columbia					42		
Percentage of Days					90.50%		

Appendix III

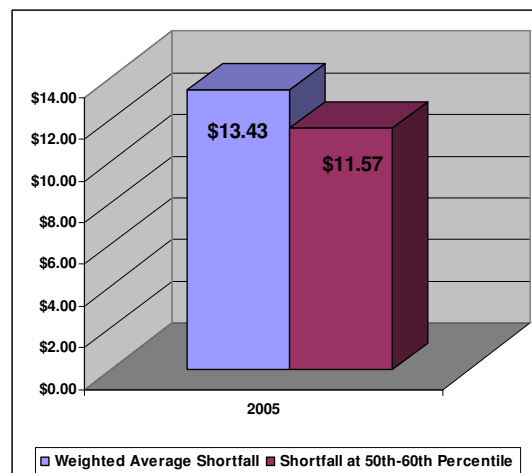
Impact of High Cost Providers on the Medicaid Average Shortfall

IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

Some researchers and analysts reviewing this report have expressed concern that the use of averages, even weighted averages, can skew the Medicaid shortfall results. The issue raised is that the inclusion of all providers, especially outliers with shortfalls significantly above or below the norm, will distort the findings.

We did find that extremely high cost providers, such as hospital-based units, tended to skew the average shortfall upward to a greater degree than the tendency of the lowest cost providers to skew the average downward. Therefore, we also examined the Medicaid shortfall of those providers whose per diem costs rank at or around the mid-range of all providers in each state. In each state, we determined the weighted average Medicaid shortfall of providers with per diem costs that rank between the 50th and 60th percentile of per diem costs of all providers. Providers at these cost levels would be considered efficient and economical under any reasonable cost standard. A graphic comparison between the weighted average shortfall for all providers and the weighted average shortfall for providers with costs between the 50th and 60th percentile is reflected in Figure V for 2005.

FIGURE V
Medicaid Shortfall Comparison – All States Weighted Average Shortfall for All Providers vs. All States Weighted Average Shortfall for Providers with Per Diem Costs at 50th - 60th Percentile



Our findings reflect that even providers whose costs are very reasonable are incurring substantial Medicaid shortfalls. When examining all the states in the study, the average Medicaid shortfall for providers whose per diem costs rank in the 50th to 60th percentile of all providers in each state was \$11.57 in 2005. This is only \$1.86 per patient day less than the average shortfall for all providers and demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.

Appendix IV

Data Collection Document (For 2005 and For Current Rates)

AHCA DATA COLLECTION INSTRUCTIONS FOR 2005 DATA

General Instructions:

Please provide Excel spreadsheets similar to those attached, identifying the difference between Medicaid allowable costs and Medicaid rates for each facility based upon 2005 cost report data. The rates must match the cost report period; not vice versa. We've attached sample spreadsheets that reflect the format and documentation that is required for this project. In essence, we need the average Medicaid rate and Medicaid allowable cost for each facility for its fiscal year that ends in 2005 and the supporting documentation reflecting the computation for each facility.

On the spreadsheets, please indicate whether the data is "as reported" or "audited/desk-reviewed" and the data source. (State agency database, etc.) We ask, if at all possible, that the data be "audited/desk-reviewed." If the data is unaudited, we ask you to provide, on a statewide basis (not by individual provider), the average historical audit adjustment percentage representing the percentage difference between "as reported" and "audited/desk reviewed" costs.

If your state utilizes a provider tax program, the tax should be included as an allowable cost, unless the Medicaid rates are net of the reimbursement for provider taxes.

Summary Tab:

This tab summarizes the weighted average Medicaid rate and allowable cost for each facility. The rate allowable cost for each facility is brought forward from the "Rates" and "Costs" tabs.

Rate Tab:

Use this tab to provide Medicaid rates by provider that correspond to their 2005 cost report period. The Medicaid rate(s) for each facility are weighted by the days or months that they were in effect during the cost report period. The rates must include any supplemental Medicaid payments facilities receive such as add-ons for specialty services or populations if the associated cost of that service is included as an allowable cost.

AHCA DATA COLLECTION INSTRUCTIONS FOR 2005 DATA

Cost Tab:

The cost tab provides an example of supporting documentation that is needed for each facility. Your worksheet will reflect the cost categories utilized in your state in determining Medicaid allowable costs. For each provider, you must indicate their fiscal year end and the number of months represented by the cost report. This information will be utilized by BDO in trending the costs to the most current rate year.

Medicaid Allowable Nursing Cost

If your state uses an acuity based system such as RUGs, the Medicaid allowable nursing cost should be determined by multiplying the total nursing cost by a ratio; the numerator being the average Medicaid Case Mix Index (CMI) and the denominator being the average overall CMI for the cost report year. For example:

Assumptions:

Total nursing cost for cost report year	\$3,000,000
Average Medicaid CMI for cost report year	0.95
Average overall CMI for cost report year	0.98

Calculation of Medicaid allowable nursing cost:

$$\$3,000,000 \quad * \quad (0.95/0.98) \quad = \quad \$2,908,163$$

Current Rates Tab

The current rates tab should reflect the most current weighted average Medicaid rates by provider; if possible, those in effect for state fiscal year 2007. If rates are set by care level, average the rates by weighting them by the percentage of Medicaid days at each care level.

AHCA DATA COLLECTION (SUMMARY)

Is the data “as reported” or “audited/desk-reviewed”	
Please make every effort to obtain data that is audited or desk reviewed. If the data is neither audited nor desk reviewed, please indicate on average what has been the historical percentage difference between unaudited and audited cost reports in your state.	
Data Source (please write in)	
In your calculation of average Medicaid cost, are nursing costs adjusted by the ratio of average Medicaid CMI to average overall CMI? (Yes or No)	

<u>FACILITY</u>	<u>PROVIDER OWNERSHIP NUMBER</u>	<u>TYPE¹</u>	<u>FACILITY YEAR END</u>	<u># OF MONTHS COVERED BY COST REPORT</u>	<u>AVERAGE MEDICAID RATE</u>	<u>AVERAGE MEDICAID COST</u>	<u>DIFFERENCE</u>	<u>TOTAL MEDICAID DAYS</u>	<u>TOTAL MEDICAID REVENUE</u>	<u>TOTAL MEDICAID COST</u>	<u>TOTAL MEDICAID PROFIT/ SHORTFALL</u>
<i>Facility 1</i>	<i>123456</i>	<i>1</i>	<i>12/31/2005</i>	<i>12</i>	<i>100.96</i>	<i>107.68</i>	<i>(6.72)</i>	<i>32,676</i>	<i>3,298,892</i>	<i>3,518,607</i>	<i>(219,715)</i>

MEDICAID RATE FOR COST REPORTING PERIOD*

* In most cases, the rate period will not correspond with the cost report period. This will require a computation averaging two or more Medicaid rates for the applicable time frame that each was in effect for the cost report period.

** In determining weighted average Medicaid rates, rates can be weighted by Medicaid days for the applicable time period or calendar days or months, depending upon the information available.

<u>FACILITY</u>	<u>PROVIDER NUMBER</u>	<u>OWNERSHIP TYPE¹</u>	<u>FACILITY YEAR END</u>	<u>MEDICAID RATE (1)</u>	<u>DAYS APPLICABLE **</u>	<u>SUBTOTAL</u>	<u>MEDICAID RATE (2)</u>	<u>DAYS APPLICABLE **</u>	<u>SUBTOTAL</u>
<i>Facility 1</i>	<i>123456</i>	<i>1</i>	<i>12/31/2005</i>	<i>100.45</i>	<i>10,849</i>	<i>1,089,782</i>	<i>101.19</i>	<i>10,939</i>	<i>1,106,917</i>

<u>MEDICAID RATE (3)</u>	<u>DAYS APPLICABLE **</u>	<u>SUBTOTAL</u>	<u>TOTAL MEDICAID REVENUE</u>	<u>TOTAL MEDICAID DAYS</u>	<u>WEIGHTED AVERAGE MEDICAID RATE PER DAY</u>
<i>101.23</i>	<i>10,888</i>	<i>1,102,192</i>	<i>3,298,892</i>	<i>32,676</i>	<i>100.96</i>

MEDICAID ALLOWABLE COST FOR COST REPORTING PERIOD

<u>FACILITY</u>	<u>PROVIDER OWNERSHIP</u>	<u>FACILITY</u>	<u>NUMBER</u>	<u>RN</u>	<u>LPN</u>	<u>AIDE</u>	<u>TOTAL</u>	<u>NURSING</u>	<u>TOTAL</u>	
<u>NUMBER</u>	<u>TYPE¹</u>	<u>YEAR END</u>	<u>OF MONTHS</u>	<u>SALARIES</u>	<u>SALARIES</u>	<u>SALARIES</u>	<u>NURSING</u>	<u>OTHER</u>	<u>NURSING</u>	
			<u>BY COST REPORT</u>				<u>SALARIES</u>		<u>EXPENSE</u>	
<i>Facility 1</i>	<i>123456</i>	<i>1</i>	<i>12/31/2005</i>	<i>12</i>	<i>486,391</i>	<i>552,251</i>	<i>886,396</i>	<i>1,925,038</i>	<i>524,424</i>	<i>2,449,462</i>

<u>MEDICAID</u>	<u>OVERALL</u>	<u>RATIO OF</u>	<u>CMI ADJUSTED</u>	<u>SOCIAL SERVICES</u>	<u>SOCIAL SERVICES</u>	<u>RECREATION</u>	<u>RECREATION</u>	<u>DIETARY</u>	<u>DIETARY</u>
<u>CMI</u>	<u>CMI</u>	<u>MEDICAID CMI</u>	<u>NURSING EXPENSE</u>	<u>SALARIES</u>	<u>OTHER</u>	<u>AND ACTIVITIES</u>	<u>AND ACTIVITIES</u>	<u>SALARIES</u>	<u>OTHER</u>
		<u>TO OVERALL CMI</u>				<u>SALARIES</u>	<u>OTHER</u>	<u>SALARIES</u>	<u>OTHER</u>
<i>0.95</i>	<i>1.00</i>	<i>0.95</i>	<i>2,326,989</i>	<i>52,609</i>	<i>11,384</i>	<i>63,970</i>	<i>25,879</i>	<i>202,997</i>	<i>284,484</i>

<u>LAUNDRY</u>	<u>LAUNDRY</u>	<u>HOUSEKEEPING</u>	<u>HOUSEKEEPING</u>	<u>A&G</u>	<u>A&G</u>	<u>MAINTENANCE</u>	<u>MAINTENANCE</u>	<u>UTILITIES</u>	<u>FRINGE</u>	<u>PROPERTY</u>	<u>PROPERTY</u>
<u>SALARIES</u>	<u>OTHER</u>	<u>SALARIES</u>	<u>OTHER</u>	<u>SALARIES</u>	<u>OTHER</u>	<u>SALARIES</u>	<u>OTHER</u>		<u>BENEFITS</u>	<u>PROPERTY</u>	<u>TAXES</u>
<i>43,742</i>	<i>21,869</i>	<i>124,122</i>	<i>47,699</i>	<i>129,899</i>	<i>288,154</i>	<i>25,255</i>	<i>64,931</i>	<i>73,964</i>	<i>528,437</i>	<i>346,453</i>	<i>28,639</i>

<u>TOTAL</u>	<u>TOTAL</u>	<u>TOTAL</u>	<u>MEDICAID</u>	<u>TOTAL</u>
<u>NON-NURSING</u>	<u>ADJUSTED</u>	<u>TOTAL</u>	<u>ALLOWABLE</u>	<u>MEDICAID</u>
<u>EXPENSE</u>	<u>EXPENSE</u>	<u>DAYS</u>	<u>EXPENSE PPD</u>	<u>DAYS</u>
<i>2,364,487</i>	<i>4,691,476</i>	<i>43,568</i>	<i>107.68</i>	<i>32,676</i>