



HANSEN HUNTER & CO. P.C.
Certified Public Accountants

A Report on Shortfalls in Medicaid Funding for Nursing Center Care

HANSEN HUNTER & COMPANY, PC
FOR THE
AMERICAN HEALTH CARE ASSOCIATION

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Medicaid Shortfalls in 2015 and Projected Shortfalls for 2017 – Nursing Center Shortfall Study Overview

Hansen, Hunter, & Company, PC (HHC) was engaged by the American Health Care Association (AHCA) to work with its state affiliates and other sources to compile information on the difference between Medicaid reimbursement and allowable Medicaid costs in as many states as feasible.¹ The report identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2015. In some states, cost reports for providers with year ends in 2016 were available and used. Similar to last year's study, a shortfall for the current year (2017) is projected by trending the 2015 costs (or 2016, if available) to the current year and comparing them to current Medicaid rates.

1. Methodology

Twenty-eight of AHCA state affiliates participated in the study and provided the most recently available cost reports (2015 for most states) to HHC. Data from almost half of the states reporting 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.²

HHC projected the shortfall in Medicaid reimbursement for the current year (2017) by comparing current year rates to 2015 allowable costs (or 2016, if available) trended to the current year. The trending factor used in projecting 2015 or 2016 costs to the current rate year was the Medicare Skilled Nursing Facility Market Basket Index (Market Basket), the same inflation index used by most states to inflate costs for rate setting purposes and by the Centers for Medicare & Medicaid Services (CMS) in setting Medicare rate increases. In addition, the trended costs were increased by the estimated cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost reports.

Historically, allowable Medicaid costs have often increased annually by a greater percentage than the Market Basket, meaning that once actual 2017 cost data become available, the actual shortfall for 2017 will likely be higher than what is projected in this report. To illustrate, authors of this study conducted a state-by-state comparison of the actual 2015 shortfalls and the shortfalls projected for that year in the April 2016 report. The comparison revealed that 20 of the participating states had greater actual shortfalls than projected.

¹ Hansen Hunter & Company P.C. (HHC) is a firm of certified public accountants and clinical consultants founded in 1979. Each partner, staff accountant, and clinical consultant has substantial experience in the health care field; the partners leading the HHC team each have more than 25 years of experience in the field.

² In some states, as-filed reports for 2015 were available and used. In others, as-filed Medicaid cost reports or Medicare cost reports were the only available reports, typically in states where rates were not based upon the most current cost report. In this situation, the state may not have audited the cost reports since they were not yet being used in the rate setting process. These cost reports, however, already exclude non-allowable costs per cost report instructions although additional adjustments would typically be made if audited by the state agency or its contractor.

2. 2015 Estimated and 2017 Projected Medicaid Shortfall

With states setting the Medicaid rates paid to nursing centers, there is a wide variation in the percentage of costs covered by the rates. In 2015, the coverage ranged from a low of 73.5 percent to a high of 100 percent. A similar range exists with the 2017 projected shortfall across the states.

3. Medicaid Allowable Costs Compared to Total Costs

If all costs of operations were considered—not just Medicaid allowable costs—the shortfall would be significantly greater. Allowable costs include only those costs recognized by the state Medicaid agency as directly or indirectly related to patient care and typically exclude necessary operating costs. Non-allowable costs include, but are 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 centers, and out-of-state travel.

Based upon historical analysis of non-allowable costs in states where such detail was available and HHC's experience preparing and analyzing cost reports, these legitimate business costs typically constitute two to three percent of total costs.

4. State-by-State Data Tables

Tables 1 and 2, on the following pages, provide an overview of state-by-state comparisons of 2015 rates to 2015 costs and 2017 rates compared to projected 2017 costs, as well as the difference in these amounts for these two years.

Table 1. State-by-State Comparison of 2015 Rates to 2015 Costs			
State	2015 Rate	2015 Cost	2015 Difference
Arizona	\$210.92	\$223.63	(\$12.71)
California	\$197.15	\$211.99	(\$14.84)
Colorado	\$232.86	\$242.85	(\$9.99)
Connecticut	\$235.92	\$258.43	(\$22.51)
Florida	\$224.47	\$237.47	(\$13.00)
Georgia ³	\$167.41	\$176.85	(\$9.44)
Hawaii	\$280.27	\$285.57	(\$5.30)
Illinois	\$155.03	\$179.25	(\$24.22)
Iowa	\$168.27	\$184.21	(\$15.94)
Kansas	\$164.59	\$183.30	(\$18.71)
Maine	\$213.16	\$230.49	(\$17.33)
Maryland	\$248.84	\$260.64	(\$11.80)
Massachusetts	\$202.82	\$236.73	(\$33.91)
Minnesota	\$180.18	\$215.60	(\$35.42)
Missouri	\$153.20	\$170.64	(\$17.44)
Montana	\$186.17	\$209.15	(\$22.98)
Nebraska	\$165.94	\$200.28	(\$34.34)
Nevada	\$206.11	\$232.04	(\$25.93)
New Jersey	\$207.94	\$244.80	(\$36.86)
New Mexico	\$172.57	\$201.06	(\$28.49)
New York ⁴	\$231.10	\$292.42	(\$61.32)
North Dakota	\$256.06	\$263.42	(\$7.36)
Ohio	\$182.61	\$201.12	(\$18.51)
South Dakota	\$131.26	\$163.39	(\$32.13)
Virginia ⁵	\$176.26	\$176.30	(\$0.04)
Washington	\$195.85	\$233.44	(\$37.59)
Wisconsin	\$167.89	\$228.53	(\$60.64)
Wyoming	\$229.25	\$252.25	(\$23.00)

³ The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

⁴ The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

⁵ The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table 2. State-by-State Comparison of 2017 Rates to Projected 2017 Costs			
State	2017 Rate	Projected 2017 Cost	Projected Difference
Arizona	\$226.77	\$236.09	(\$9.32)
California	\$209.97	\$219.46	(\$9.49)
Colorado	\$231.39	\$247.98	(\$16.59)
Connecticut	\$237.38	\$263.20	(\$25.82)
Florida	\$226.50	\$242.70	(\$16.20)
Georgia ⁶	\$172.30	\$183.23	(\$10.93)
Hawaii	\$286.96	\$292.26	(\$5.30)
Illinois	\$156.00	\$181.82	(\$25.82)
Iowa	\$173.53	\$192.98	(\$19.45)
Kansas	\$169.10	\$187.49	(\$18.39)
Maine	\$216.37	\$234.42	(\$18.05)
Maryland	\$250.93	\$265.55	(\$14.62)
Massachusetts	\$207.04	\$246.89	(\$39.85)
Minnesota	\$225.17	\$226.09	(\$0.92)
Missouri	\$158.91	\$177.81	(\$18.90)
Montana	\$191.14	\$219.40	(\$28.26)
Nebraska	\$169.33	\$205.40	(\$36.07)
Nevada	\$206.63	\$237.12	(\$30.49)
New Jersey	\$208.64	\$255.76	(\$47.12)
New Mexico	\$172.59	\$203.91	(\$31.32)
New York ⁷	\$243.33	\$307.51	(\$64.18)
North Dakota	\$257.87	\$271.33	(\$13.46)
Ohio	\$189.37	\$203.98	(\$14.61)
South Dakota	\$139.02	\$170.30	(\$31.28)
Virginia ⁸	\$178.34	\$183.29	(\$4.95)
Washington	\$200.37	\$236.37	(\$36.00)
Wisconsin	\$170.57	\$234.28	(\$63.71)
Wyoming	\$249.30	\$263.81	(\$14.51)

⁶ The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

⁷ The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

⁸ The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Outlook for Medicaid Financing

Over the course of 2017, the House and Senate considered various bills that made sweeping changes to the structure and financing of the Medicaid program. In the future, due to continued Medicaid growth and concerns about federal and state program oversight, it is likely that Congress will consider changes that could result in shifting Medicaid program costs to states, beneficiaries, and providers. This could have a devastating impact on a profession already struggling to deliver care and supports at Medicaid payment rates that do not adequately cover the costs of such care. Even in the absence of federal reforms, there are significant changes that states could elect to make under existing authorities, such as 1115 demonstrations that could impact nursing center care.

In an effort to control growth of the federal deficit, Congress enacted the Budget Control Act of 2012 (BCA), which set caps on security and non-security budget authority.⁹ Since Congress did not act upon legislation aimed at reining in spending, the BCA spending caps were reset to apply to the 2013 through 2021 budgets. Additionally, automatic procedures went into effect to reduce both discretionary and mandatory spending during that period (e.g., sequestration), with \$1.2 trillion in cuts going into effect in March 2013, including cuts to Medicare but not Medicaid, which was excluded.

Another factor that could potentially influence financing in the future is the number of seniors living in poverty. Research based on the Census Bureau's supplemental poverty measure indicates that the poverty rate among people ages 65 and older may be higher than is reflected in the official poverty measure, and is particularly high in some states. Although there are notable differences between the two measures, there is ongoing interest in assessing these methods for measuring poverty.¹⁰ If these data prove correct and more seniors are living in poverty than expected, this could have significant implications on any policy changes Congress considers to entitlement programs such as Social Security and Medicare, which could in turn affect the Medicaid program.

Nursing Center Outlook

Historically, nursing centers have struggled with Medicaid rates insufficient to cover the costs of delivering care to an increasingly frail and medically complex population. The future appears to hold additional instability. Among the states, key trends impacting nursing center capacity include increasingly tight Medicaid long term services and supports (LTSS) budgets as states expand home and community-based services to meet growing demand and expanding use of Medicaid managed LTSS, as well as decreasing occupancy.

⁹ Congressional Budget Office. Sequestration Update Report: August 2012.

¹⁰ Levinson, Z. et al. A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure. May, 2013. <http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8442-state-by-state-snapshot-of-poverty-among-seniors-may.pdf>

State economic health varies significantly. Although most states saw improved revenue conditions in fiscal year 2018 following slowdowns during the previous two years, in some cases these improvements have been bolstered by increases in taxes. Although total state general fund revenues grew at an estimated 4.9 percent in 2018, the median revenue growth is 2.7 percent, which demonstrates the variation in growth states are experiencing.¹¹

At the federal level, the sequestration includes some reductions in Medicare reimbursement, impacting an already fragile industry delivering care and supports to some of the nation's most vulnerable citizens. Additionally, CMS is in the process of overhauling its Medicare payment system for skilled nursing centers, which will change payment incentives for providers, as well as require operational changes to operate in this new system, with the current Resource Utilization Group-IV payment model being replaced by the Patient-Driven Payment Model on October 1, 2019. While it is too early to tell what the impact will be on the provider landscape, previous payment system changes have forced dramatic changes to the industry, and current Medicare changes could well impact state Medicaid reimbursement methodologies.

In the near term, as Congress considers additional changes to Medicare or Medicaid, it is possible further changes will be considered to bad debt, provider tax, and supplemental payments, as well as broader financing changes to the program writ large. If Congress were to make such changes, state Medicaid agencies and the profession would suffer significant budgetary challenges. However, the federal government does not necessarily need to act in order for significant changes to be made at the state level. Through the use of 1115 demonstrations, there is tremendous flexibility for states and the federal government to overhaul their Medicaid programs. While these changes may initially focus on certain populations that do not impact nursing centers, it remains to be seen how broad some governors may go using this authority to change Medicaid in their state.

The federal government and states also are experimenting with payment and service delivery system innovations including Medicare and Medicaid Accountable Care Organizations (ACOs), Medicare-Medicaid integration efforts, and Medicare and Medicaid bundled payment methodologies. While it is unclear how these approaches will impact the nursing center sector in the long term, providers are raising preliminary concerns about excessive pressures to reduce overall spending, while maintaining and/or improving quality of care, associated with these payment reform movements.

In conclusion, current financial challenges and future uncertainty paints a difficult picture for the nursing center sector. As the number of older adults increase and the profession continues to see rising levels of multiple chronic conditions, the ability to meet the needs and expectations of the growing elderly and disabled populations without major overhauls in how the services are funded is major cause for concern.

¹¹ The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2018.

Appendices

Appendix 1
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 and agreed to participate 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 year ending in 2015 (or 2016, if available). 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 2015, but between current (FY 2017) rates and 2015 (or 2016, if available) costs trended to the same time period.¹²

HHC was 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 centers, and out-of-state travel. The cost database reflected costs that have been audited or desk-reviewed by the Medicaid state agency in almost two-thirds of the participating states. HHC did not replicate the calculations nor trace individual center cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 2015 (or 2016 if available) were derived for 28 states. Current Medicaid rates by provider were also obtained, allowing us to determine an estimated 2017 shortfall for these states. States included in this report reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide.

¹² Some state affiliates did not participate either through their own choice or because the data were not available.

Appendix 2

**Calculation of 2015 and Projected 2017
Weighted Average Medicaid Shortfall
State-by-State Comparison**

Table A2-1. Calculation of 2015 Weighted Average Medicaid Shortfall							
State	2015 Rate	2015 Cost	2015 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona	\$210.92	\$223.63	(\$12.71)	2,522,150	\$531,971,878	\$564,028,405	(\$32,056,527)
California	\$197.15	\$211.99	(\$14.84)	23,345,035	\$4,602,473,650	\$4,948,913,970	(\$346,440,319)
Colorado	\$232.86	\$242.85	(\$9.99)	3,590,140	\$836,000,000	\$871,865,499	(\$35,865,499)
Connecticut	\$235.92	\$258.43	(\$22.51)	6,000,600	\$1,415,661,552	\$1,550,735,058	(\$135,073,506)
Florida	\$224.47	\$237.47	(\$13.00)	15,288,390	\$3,431,851,209	\$3,630,573,570	(\$198,722,361)
Georgia ¹³	\$167.41	\$176.85	(\$9.44)	8,719,850	\$1,459,790,089	\$1,542,105,473	(\$82,315,384)
Hawaii	\$280.27	\$285.57	(\$5.30)	827,090	\$231,808,514	\$236,192,091	(\$4,383,577)
Illinois	\$155.03	\$179.25	(\$24.22)	15,404,095	\$2,388,096,848	\$2,761,184,029	(\$373,087,181)
Iowa	\$168.27	\$184.21	(\$15.94)	4,284,005	\$720,869,521	\$789,156,561	(\$68,287,040)
Kansas	\$164.59	\$183.30	(\$18.71)	3,508,015	\$577,384,189	\$643,019,150	(\$65,634,961)
Maine	\$213.16	\$230.49	(\$17.33)	1,439,925	\$306,934,413	\$331,888,313	(\$24,953,900)
Maryland	\$248.84	\$260.64	(\$11.80)	5,470,620	\$1,361,309,081	\$1,425,862,397	(\$64,553,316)
Massachusetts	\$202.82	\$236.73	(\$33.91)	9,037,035	\$1,832,891,439	\$2,139,337,296	(\$306,445,857)
Minnesota	\$180.18	\$215.60	(\$35.42)	4,939,545	\$890,007,218	\$1,064,965,902	(\$174,958,684)
Missouri	\$153.20	\$170.64	(\$17.44)	8,788,470	\$1,346,393,604	\$1,499,664,521	(\$153,270,917)
Montana	\$186.17	\$209.15	(\$22.98)	938,780	\$174,772,673	\$196,345,837	(\$21,573,164)
Nebraska	\$165.94	\$200.28	(\$34.34)	2,255,335	\$374,250,290	\$451,698,494	(\$77,448,204)
Nevada	\$206.11	\$232.04	(\$25.93)	1,024,190	\$211,095,801	\$237,653,048	(\$26,557,247)
New Jersey	\$207.94	\$244.80	(\$36.86)	9,726,520	\$2,022,532,569	\$2,381,052,096	(\$358,519,527)
New Mexico	\$172.57	\$201.06	(\$28.49)	1,303,050	\$224,867,339	\$261,991,233	(\$37,123,895)
New York ¹⁴	\$231.10	\$292.42	(\$61.32)	25,705,855	\$5,940,623,091	\$7,516,906,119	(\$1,576,283,029)
North Dakota	\$256.06	\$263.42	(\$7.36)	1,043,535	\$267,207,572	\$274,887,990	(\$7,680,418)

¹³ The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

¹⁴ The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table A2-1.							
State	2015 Rate	2015 Cost	2015 Difference	Annual Medicaid	Gross Revenue	Gross Cost	Total Difference
Ohio	\$182.61	\$201.12	(\$18.51)	16,479,385	\$3,009,300,495	\$3,314,333,911	(\$305,033,416)
South Dakota	\$131.26	\$163.39	(\$32.13)	1,205,960	\$158,294,310	\$197,041,804	(\$38,747,495)
Virginia ¹⁵	\$176.26	\$176.30	(\$0.04)	5,962,640	\$1,050,974,926	\$1,051,213,432	(\$238,506)
Washington	\$195.85	\$233.44	(\$37.59)	3,663,505	\$717,497,454	\$855,208,607	(\$137,711,153)
Wisconsin	\$167.89	\$228.53	(\$60.64)	5,451,640	\$915,275,840	\$1,245,863,289	(\$330,587,450)
Wyoming	\$229.25	\$252.25	(\$23.00)	514,285	\$117,899,836	\$129,728,391	(\$11,828,555)

¹⁵ The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation material ly distorts the shortfall being incurred by the other facilities in the state.

Table A2-2. Calculation of Projected 2017 Weighted Average Medicaid Shortfall							
State	2017 Rate	2017 Cost	2017 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona	\$226.77	\$236.09	(\$9.32)	2,548,795	\$577,990,242	\$601,745,012	(\$23,754,769)
California	\$209.97	\$219.46	(\$9.49)	22,770,890	\$4,781,203,773	\$4,997,299,519	(\$216,095,746)
Colorado	\$231.39	\$247.98	(\$16.59)	3,666,425	\$848,374,081	\$909,200,072	(\$60,825,991)
Connecticut	\$237.38	\$263.20	(\$25.82)	5,896,575	\$1,399,728,974	\$1,551,978,540	(\$152,249,567)
Florida	\$226.50	\$242.70	(\$16.20)	15,424,535	\$3,493,657,178	\$3,743,534,645	(\$249,877,467)
Georgia ¹⁶	\$172.30	\$183.23	(\$10.93)	8,770,585	\$1,511,171,796	\$1,607,034,290	(\$95,862,494)
Hawaii	\$286.96	\$292.26	(\$5.30)	828,550	\$237,760,708	\$242,152,023	(\$4,391,315)
Illinois	\$156.00	\$181.82	(\$25.82)	14,458,015	\$2,255,450,340	\$2,628,756,287	(\$373,305,947)
Iowa	\$173.53	\$192.98	(\$19.45)	4,000,035	\$694,126,074	\$771,926,754	(\$77,800,681)
Kansas	\$169.10	\$187.49	(\$18.39)	3,402,895	\$575,429,545	\$638,008,784	(\$62,579,239)
Maine	\$216.37	\$234.42	(\$18.05)	1,453,430	\$314,478,649	\$340,713,061	(\$26,234,412)
Maryland	\$250.93	\$265.55	(\$14.62)	5,587,420	\$1,402,051,301	\$1,483,739,381	(\$81,688,080)
Massachusetts	\$207.04	\$246.89	(\$39.85)	9,057,475	\$1,875,259,624	\$2,236,200,003	(\$360,940,379)
Minnesota	\$225.17	\$226.09	(\$0.92)	4,832,965	\$1,088,238,729	\$1,092,685,057	(\$4,446,328)
Missouri	\$158.91	\$177.81	(\$18.90)	9,073,170	\$1,441,817,445	\$1,613,300,358	(\$171,482,913)
Montana	\$191.14	\$219.40	(\$28.26)	923,085	\$176,438,467	\$202,524,849	(\$26,086,382)
Nebraska	\$169.33	\$205.40	(\$36.07)	2,236,720	\$378,743,798	\$459,422,288	(\$80,678,490)
Nevada	\$206.63	\$237.12	(\$30.49)	1,067,625	\$220,603,354	\$253,155,240	(\$32,551,886)
New Jersey	\$208.64	\$255.76	(\$47.12)	9,319,545	\$1,944,429,869	\$2,383,566,829	(\$439,136,960)
New Mexico	\$172.59	\$203.91	(\$31.32)	1,367,290	\$235,980,581	\$278,804,104	(\$42,823,523)

¹⁶ The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table A2-2. Calculation of Projected 2017 Weighted Average Medicaid Shortfall							
State	2017 Rate	2017 Cost	2017 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
New York ¹⁷	\$243.33	\$307.51	(\$64.18)	23,880,125	\$5,810,750,816	\$7,343,377,239	(\$1,532,626,423)
North Dakota	\$257.87	\$271.33	(\$13.46)	1,068,720	\$275,590,826	\$289,975,798	(\$14,384,971)
Ohio	\$189.37	\$203.98	(\$14.61)	16,494,350	\$3,123,535,060	\$3,364,517,513	(\$240,982,454)
South Dakota	\$139.02	\$170.30	(\$31.28)	1,170,920	\$162,781,298	\$199,407,676	(\$36,626,378)
Virginia ¹⁸	\$178.34	\$183.29	(\$4.95)	6,104,260	\$1,088,633,728	\$1,118,849,815	(\$30,216,087)
Washington	\$200.37	\$236.37	(\$36.00)	3,599,995	\$721,330,998	\$850,930,818	(\$129,599,820)
Wisconsin	\$170.57	\$234.28	(\$63.71)	5,018,020	\$855,923,671	\$1,175,621,726	(\$319,698,054)
Wyoming	\$249.30	\$263.81	(\$14.51)	538,010	\$134,125,893	\$141,932,418	(\$7,806,525)

¹⁷ The Medicaid rate does not include the supplemental payments made to 35 non -state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

¹⁸ The Medicaid rate does not include the supplemental payments made to 5 non -state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.