DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations (CMSO)

Dr. Jerry Dubberly, PharmD.
Chief, Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303-3159

FEB 1 8 2010

RE: State Plan Amendment 09-007

Dear Dr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 09-007. Effective July 1, 2009 this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, this amendment will implement the fair rental value method to reimburse property costs and increases the incentive fees paid to facilities that meet specific criteria for quality measures.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of July 1, 2009. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at 410-786-8281.

Sincerely

[redacted]

Cindy Mann
Director, CMSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-007

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.200, 331

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ 6,586,456
FFY 2011 $26,555,933

"8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pp. 1-33

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, pp.1-53

10. SUBJECT OF AMENDMENT:
NURSING FACILITY PAYMENT RATES

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME: Jerry Dubberly

14. TITLE: Chief, Division of Medicaid

15. DATE SUBMITTED:08-12-09

16. RETURN TO:
Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08-12-09

18. DATE APPROVED: 02-18-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Cindy Mann

22. TITLE: Director, CMSO

23. REMARKS: Approved with the following changes to 7 as authorized by state agency.

Block #7 changed to read: FFY 2009 $6,454,282; FFY 2010 $26,384,161.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

The following sections summarize the methods and procedures for determining nursing facility reimbursement rates in the format prescribed by the Department of Health and Human Services (DHHS). Complete documentation is found in the Policies and Procedures for Nursing Facility Services provider manual (Manual), Chapter 1000, effective July 1, 2009, located at the Georgia Health Partnership web portal at https://www.ghp.georgia.gov/wps/portal.

A. Cost Finding and Cost Reporting

1. All nursing facilities are required to report costs for the twelve months ending June 30th of each year. Cost report instructions are published by July 31st of each year for use during that State fiscal year. Release of the instructions may be delayed on occasion in order to implement significant policy changes.

2. All nursing facilities are required to detail their entire costs for the reporting year, or for the period of participation in the plan (if less than the full cost reporting year) for allowable costs under the Georgia Plan. These costs are reported by the facility using a Uniform Chart of Accounts prescribed by the State Agency and on the basis of generally accepted accounting principles and accrual methods of accounting.

   (a) All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September 30 must submit cost reports on or before December 31 using the most recent complete fiscal year cost data. All other facilities are required to submit cost reports on or before September 30 of the year in which the reporting period ends.

   (b) All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

3. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.

4. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 2a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.

B. Audits

1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:

   (a) The development of standards of reasonableness for each major cost center of a nursing facility;

   (b) The development of a computerized desk review process for the submitted uniform cost reports; and

   (c) The development of a detailed on-site audit plan, using generally accepted auditing standards.

   The standards, desk review, and on-site audits ensure that only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, are included in the facility's uniform cost report and that the expense items included are accurately determined and are reasonable.

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30th to verify that the facility has complied with paragraphs 2 and 3 above in Section A.

3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further auditing of the facility's financial and statistical records and other documents will be conducted as needed.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

4. On-site audits of the financial and statistical records will be performed annually in at least 15 percent of participating facilities. Such on-site audits of financial and statistical records will be sufficiently comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.

5. The on-site audits conducted in accordance with Section B, paragraph 4 above shall produce an audit report which shall meet generally accepted auditing standards. The report shall declare the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.

6. Any overpayments found in audits under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

C. Allowability of Costs

The Department uses the Centers for Medicare and Medicaid Services Manual (CMS-15-1), Medicare principles, as a guide to determine allowable and non-allowable costs. However, in situations where warranted, the Department has developed policy regarding cost allowability outside of CMS-15-1. In addition to the use of CMS-15-1 as a guide, the Department describes specific cost allowability in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000. The following paragraphs offer a general discussion of allowability of costs.

1. Allowable Costs Include the Following:

a) The cost of meeting certification standards. These costs include all items of expense which providers must incur to meet the definition of nursing facilities under Title XIX statutory and regulatory requirements and as otherwise prescribed by the Secretary of HHS for nursing facilities; in order to comply with requirements of the State Agency responsible for establishing and maintaining health standards; and in order to comply with any other requirements for nursing facility licensing under the State law;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

b) All items of expense which providers incur in the provision of routine services. Routine services include the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Additional allowable costs include depreciation, interest, and rent expense as defined in the principles of reimbursement in CMS-15-1, except that actual malpractice insurance costs are reimbursed as reported in the facility's cost report, subject to audit verification; and

c) Costs applicable to services, facilities, and supplies furnished to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Providers are required to identify such related organizations and costs on the State's uniform cost report.

2. Non-Allowable Costs Include the Following:

a) Bad debts of non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs. The only bad debts allowable are those defined in 42 CFR 4 13.80. The value of operating rights and licenses and/or goodwill is not an - allowable cost and is not included in the computation of the return on equity;

b) Effective for the determination of reasonable costs used in the establishment of reimbursement rates on and after April 1, 1991, the costs listed below are nonallowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
- Memberships in civic organizations;
- Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

provider. Out-of-state travel for provider personnel must be related to patient care;

- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

- Fifty percent (50%) of membership dues for national, state and local associations;

- Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fund raising purposes; (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation; (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying; and

- The cost of home office vehicle expense.

D. Methods and Standards for Determining Reasonable Cost-Related Payments

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

The 2006 cost report, using the reporting format and underlying instructions established by the Department, will be used to determine a facility's allowable cost that will be the basis for computing a rate.

1. Nursing Facility and ICF/MR Methods and Standards

The methods and standards for the determination of reimbursement rates to nursing facilities, and intermediate care facilities for the mentally retarded is as described in Chapter 1000 of the Manual effective July 1, 2009.

2. Prospective Rates

Payment rates to nursing facilities and ICF/MRs are determined prospectively using costs for a base period. The cost reports are updated periodically according to Part I, Chapter 400 and Appendix I of the Manual effective July 1, 2009. For dates of service beginning July 1, 2009, the 2006 Cost Report is the basis for reimbursement.

3. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of the Manual effective July 1, 2009.

4. Additional Details

Detailed information regarding this methodology is maintained on file in the State Agency as Chapter 1000 of the Manual effective July 1, 2009.

E. Payment Assurances

The State will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in Section D, above.

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

F. Provider Participation

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program; so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

G. Payment in Full

Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

H. Payment Limitation Applicable to Patients in Nursing Facilities with Medicare Part A Entitlement

Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of services of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

Daily cost-sharing charges for beneficiaries will commence on the 21st day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

I. Nurse Aide Training

The Department adjusts per diem payment rates to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment does not apply to ICF/MR facilities. Beginning with dates of service July 1, 1992, and after, the Department will not adjust reimbursement rates for the cost of replacement wages and overtime for nurse aide training and testing because these costs are included in the 1991 cost reports.

J. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

K. Reimbursement Methodology

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in provisions of Part II - Appendix 1 of the Manual.

L. Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate

For dates of service beginning July 1, 2009, the 2006 Cost Report is the basis for reimbursement. For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem +Efficiency Per Diem +Growth Allowance +Other Rate Adjustments

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available) for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

Standard Per Diem =

Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant;Administrative and General; and Property and Related) is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be multiplied by the Maximum Percentile, or a median net per diem shall be chosen, with the Maximum Cost per day being determined as a percentage of the median.

The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for efficiency incentive payments is 105% of the median cost per day within each peer group. The Maximum Percentile is the eighty-fifth for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for Hospital-Based Nursing Facility group and the ninetieth percentile for the Freestanding Nursing Facility group and the Intermediate Care Facility for the Mentally Retarded group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division on June 30, 2007. Standards effective July 1, 2009, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center. The following examples show groupings by Net Per Diem:

Routine and Special Services Maximum Percentile at 90%

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

Maximum Percentile Standard Determination

(10 net per diems) X (90^{th} percentile) = 9^{th} position or $135

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

Administrative and General Maximum Cost at 105% of Median

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140, $150

Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the per diem amount that falls in the middle of the group or $120

$120 x 105% =$126

Administrative and General Maximum Cost at 105% of Median (Interpolation)

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the average of the two middle net per diem amounts that fall in the middle of the group ($115 +$120/ 2 =$118)

$118 x 105% =$124

There are several instances where a facility could fall in more than one group. Intermediate care facilities for the mentally retarded which also are nursing facilities are classified as intermediate care facilities for the mentally retarded and not grouped with other nursing facilities.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility (e.g., nursing facility, hospital-based nursing facility, or

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

intermediate care facility for the mentally retarded.)it is as of the date the Standard Per Diem is calculated.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes, as indicated above, for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

Allowed Per Diem =

Summation of the Net Per Diem or Standard Per Diem, whichever amount is less. This applies to the allowed per diem for the Dietary, Laundry and Housekeeping, Plant Operations and Maintenance and Administrative and General cost centers. For the Property and Related cost centers, the methodology described in the Section N (Property and Related Reimbursement) shall apply. The Allowed Per Diem for Taxes and Insurance shall be equal to the Net Per Diem for this cost center. The resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available.

Efficiency Per Diem =

The Efficiency Per Diem is calculated by summing the Standard Per Diem minus 75% of the Net Per Diem , to arrive at the Maximum Efficiency Per Diem for each of the four Non-Property Cost Centers.

Growth Allowance =

Summation of 1.19% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; and Administrative and General).

Further explanation of these terms is included below:

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a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports (as defined in Section 1002 in the Manual under "cost center") are determined by utilizing the information submitted by the facility on its Cost Report.

All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs by the Manual, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; as defined in the Manual. These modifications define what expenses are attributable to the care received and the allowable expenses that are attributable to care. See Appendix I of the Manual for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule references are to the Cost Report):

See Section 1002.5 of the Manual for additional description of such limitations.

Allowable Home Office salary costs are limited to an appropriate maximum. Fringe benefits are also limited to an appropriate maximum. A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a $100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of $100,000 to be applied only to owners of nursing facilities and related parties. Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

Routine and Special Services Net Per Diem

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 6); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified in section 1002.2 of the manual. The method by which a case mix index score is calculated is described in Appendix D (Uniform Chart Of Accounts, Cost Reporting, Reimbursement Principles And Other Reporting Requirements) of the manual.

ICF-MR Routine Services and Special Services Net Per Diem =

Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 7.

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs. The example below shows the treatment of these costs:

Total Routine Services Cost, (Medicaid Cost Report Schedule B, Line 6, Column 4):	$5,000,000
Patient Days	
Total Medicaid ICF-MR Patient Days (Medicaid Cost Report Schedule A, Line 13, Sum of Columns 4, 5, and 6):	40,000 80%
Total Medicaid NF Patient Days (Medicaid Cost Report Schedule A, Line 13, Sum of Columns 4, 5, and 6):	10,000 20%
Total Patient Days:	50,000 100%

Allocation

Routine Services Cost allocated to ICF-MR (Schedule B, Line 6, Column 4 is $5,000,000 x 80% =$ 4,000,000)

Routine Services Cost allocated to NF (Schedule B, Line 6, Column 4 is $5,000,000 x 20% =$1,000,000)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

Dietary Net Per Diem =

Historical Dietary, Schedule B (Medicaid Cost Report), Line 8, Column 4, Divided By Total Patient Days

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of Plant, Schedule B (Medicaid Cost Report), Lines 9 plus 10, Column 4, Divided By Total Patient Days

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B (Medicaid Cost Report),, Line 11, Column 4, Divided By Total Patient Days

Property and Related Net Per Diem =

Historical Property and Related costs (Schedule B (Medicaid Cost Report), Line 12, Column 4) are divided By Total Patient Days. The resulting net per diem will be adjusted to the greater of the facility's Dodge Rate, or the approved property reimbursement per diem in effect as of July 1, 2009, or the Fair Rental Value System per diem rate. Property reimbursement under FRVS will replace use of the Dodge index over a three year period beginning July 1, 2009. FRV reimbursement beginning July 1, 2009, shall not increase by more than 150% of the amount that would have been paid using the Dodge index alone but will also be no less than the property per diem based on the Dodge index or the approved property reimbursement per diem in effect on June 30, 2009. After three years FRV will replace the property component determined by the Dodge index and any otherwise previously approved property reimbursement per diem.

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Costs for property taxes and property insurance, as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost center Standard Per Diem.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

There is no standard per diem for this cost center.

c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the four Non-Property cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero ($0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by 0.75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums which have been established through legislative authority:

Routine and Special Services Maximum Efficiency Payment	$0.53
Dietary Maximum Efficiency Payment	$0.22
Laundry and Housekeeping and Operation and Maintenance of Plant Maximum Efficiency Payment	$0.41
Administrative and General Maximum Efficiency Payment	$0.37

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M. Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

1. If the Department determines that a cost report cannot be used to set a billing rate the per diem rate will be established, as follows:

a) When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Appendix D2(h) of the manual.)

b) Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.

c) In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports.

The Total Allowed Per Diem Billing Rate for homes with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to the Fair Rental Value Rate as determined under Section N.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY SERVICES

d) In all other instances where the Department determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports. If the Department determines that a cost report which was to be used to set a reimbursement rate is unauditable (i.e., the Department's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk audit or on-site audit), or unreliable (See Appendix D2(h) of the manual), the Department may reimburse the facility the lower of the following:

- The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditable cost report;
- The Total Allowed Per Diem Billing Rate calculated from the unauditable cost report; or
- The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

e) If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department will use the average score for all facilities.

N. Property and Related Reimbursement

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1. Effective for dates of service on and after July 1, 2009, the Property and Related Net Per Diem shall be the higher of: (i) such Per Diem being paid as of June 30, 2009 (based on the Dodge index); or (ii) the amount computed using the fair rental value (FRV) reimbursement system described below. Property reimbursement under FRV will replace use of the Dodge index over a three year period beginning July 1, 2009. FRV reimbursement beginning July 1, 2009, shall not increase by more than 150% of the amount that would have been paid using the Dodge index alone but will also be no less than the amount based on the Dodge index or the approved property reimbursement per diem in effect on June 30, 2009. After three years FRV will replace the property component determined by the Dodge index and previously approved property reimbursement per diems. Under a FRV system, a facility is reimbursed on the basis of the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent / lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility, its location, and its total square footage.
2. The Property and Related Net Per Diem initially established under the FRV system shall be calculated as follows:
   (a) Effective for dates of service on and after July 1, 2009, the value per square foot shall be based on the $141.10 construction cost for nursing facilities, as derived from the 2009 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction). The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code as well as by a Construction Cost Index which is initially set at 1.000. The resulting product is the Adjusted Cost per Square Foot.
   (b) A Facility Replacement Value is calculated by multiplying the Adjusted Cost per Square Foot by the Allowed Total Square Footage. The latter figure is the lesser of a nursing facility's actual square footage (computed using the gross footage method)

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compared to the number of licensed beds times 700 square feet (the maximum allowable figure per bed).

(c) An Equipment Value is calculated by multiplying the number of licensed beds by $6,000 (the amount allowed per bed) and by an initial Equipment Cost Index of 1.000.

(d) A Depreciated Replacement Value is calculated by depreciating the sum of the Facility Replacement Value and the Equipment Value. The amount depreciated is determined by multiplying the Adjusted Facility Age, discussed in all of (N)(5), by a 2% Facility Depreciation Rate. The initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.

(e) The Land Value of a facility is calculated by multiplying the Facility Replacement Value by15% to approximate the cost of land.

(f) A Rental Amount is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying this figure by a Rental Rate which is 9.0% effective July 1, 2009.

(g) The Annual Rental Amount is divided by the greater of the facility's actual cumulative resident days during the 2006 cost reporting period or 85% of the licensed bed capacity of the facility multiplied by 365. The resulting figure constitutes the Property and Related Net Per Diem established under the FRV system.

An example of how the Property and Related Net Per Diem is calculated is presented in the following table.

Example Calculation of Initial Fair Rental Value Per Diem

Ref	Data Element	Example Data	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Criteria

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D	Adjusted Base Year	1989	Based on Initial Age adjusted by Bed Additions and Facility Renovations
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68,857	Department Data
G	Nursing Facility Zip Code	30312	Department Data
H	Total Patient Days	48,552	Department Data
I	Per Bed Square Footage Limit	700	Department Criteria
J	Maximum Allowable Square Footage	96,600	E x I
K	Allowed Total Square Footage	68,857	lesser of F or J
L	Rate Year RS Means Cost per Square Foot	$141.10	RS Means lookup based on Rate Year
M	RS Means Location Factor	0.9	RS Means lookup based on Zip Code (G)
N	Construction Cost Index	1	Department Criteria
O	Adjusted Cost per Square Foot	$126.99	L x M x N
P	Facility Replacement Value	$8,744,150	K x O
Q	Equipment Allowance	$6,000	Department Criteria
R	Equipment Cost Index	1	Department Criteria
S	Equipment Value	$828,000	E x Q x R
T	Facility Value Excluding Land	$9,572,150	P +S
U	Bed Additions and Facility Renovations	-	Separate calculations affecting the Nursing Facility A (see D and V)
V	Nursing Faciity Age	20	C - D (D is based on initial age adjusted by additions renovations per U)
W	Maximum Years for FRV Age	25	Department Criteria
X	FRV Adjusted Facility Age	20	lesser of V or W
Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	$3,828,860	T x X x Y
AA	Depreciated Replacement Value	$5,743,290	T - Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	$1,311,623	P x AB
AD	Depreciated Replacement Value & Land	$7,054,913	AA +AC
AE	Rental Rate	9.00%	Department Criteria
AF	Rental Amount	$634,942	AD x AE

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AG	Minimum Occupancy Percentage	85.00%	Department Criteria
AH	Bed Days at Minimum Occupancy	42,815	E x 365 x AG
AI	Total Allowed Patient Days	48,552	higher of H or AH
AJ	Fair Rental Value Per Diem	$13.08	AF / AI
AK	06/30/09 Property and Related Net Per Diem	$5.43	Department Data (Dodge Index)
AL	Property and Related Net Per Diem	$13.08	Greater of AJ or AK, but not more than a 150% incre of AK

3. The Property and Related Net Per Diem initially established under (N)(2) shall be updated annually on July 1, effective for dates of service on and after July 1, 2010 as follows:
   (a) The value per square foot shall be based on the construction cost for nursing facilities, as derived from the most recent RSMeans Building Construction cost data available on June 1st of each year. The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code and by using a cost index to correspond to annual state appropriations.
   (b) A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. All partial replacements will be treated as renovations and will have their base year age adjusted based on the methodology proscribed for a renovation.

4. A Renovation Construction Project shall mean a capital expenditure (as defined in Section (N)(4)(a)) that exceeds $500 per existing

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licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of O.G.C.A. § 290-5-8

(a) Allowable capital expenditures include the costs of buildings, machinery, fixtures, and fixed equipment (see Table 5 in Estimated Useful Lives of Depreciable Hospital Assets (Revised 2008 Edition), published by Health Forum, Inc, for a complete listing of allowable items) constituting any New Construction Project as referenced in paragraph 4, above. The exception to this requirement is for telemedicine terminals, solar panels, tankless water heaters and low flow toilets. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider Reimbursement Manual (CMS-15-1) or are betterments or improvements which meet the criteria of §108.2 of the Provider Reimbursement Manual (CMS-15-1) or which materially (a) expand the capacity, (b) reduce the operating and maintenance costs, (c) significantly improve safety or (d) promote energy conservation.

5. For purposes of the FRV calculation, the age of each facility shall be determined as follows:
   (a) The initial age of each facility shall be determined as of July 1, 2009, comparing 2009 to the later of the facility's year of construction or the year the building was first licensed as a nursing facility; provided, however, that such age will be reduced for Construction Projects, or bed additions that occurred subsequent to the initial construction or conversion of the facility but prior to July 1, 2009.
   (b) For periods subsequent to July 1, 2009, the FRV adjusted age determined in (N)(5)(a) of a facility will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2009, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bed additions will be effective the first day of the calendar quarter subsequent to such project being completed and placed into service.

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(c) Once initial rates are established under the FRV reimbursement system, subsequent calculations of the FRV adjusted age will be determined by subtracting the adjusted base year (derived by calculating the impact of bed additions and facility renovations) from the rate setting year. The FRV adjusted age will be recalculated each July 1 to make the facility one year older, up to the maximum age of 32.5 years and will be done in concert with the calculations of the Value per Square Foot as determined in section (N)(3)(a). Age adjustments and Rate adjustments are not synonymous.

(d) If a facility has added beds, the age of these additional beds will be averaged in with the age of the remaining beds, and the weighted average age for all beds will be used as the facility's age. An example of how an addition would reduce the age of the facility is presented in the following table:

Example Calculation of the Impact of an Addition on a Nursing Facility's Base Year

Ref	Data Element	Example Data	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	123456789A	Department Data
C	Year Bed Additions were Completed	1981	Department Criteria
D	Base Year Prior to Additions	1970	Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
E	Existing Beds prior to Bed Additions	130	Department Data
F	Number of Beds Added	8	Department Data
G	Age of Existing Beds when Additions were Completed	11	C - D

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H	Weighted Average of Existing Beds	1430	E x G
I	Total Beds After Bed Additions were Completed	138	E +F
J	Base Year Age Adjustment	10.36	H / I
K	New Base Year	1,971.00	C - J (rounded)

(e) If a facility performed a Renovation Construction Project as defined in section (N)(4), the cost of the Project will be converted to an equivalent number of replacement beds by dividing the value of the renovation by the depreciated bed replacement value.

i. The renovation completion date will be used to determine the year of renovation.

ii. An Age Index factor will be used to calculate a bed replacement cost for any renovation occurring prior to July 1, 2009. The Age Index factor is derived by using the 2009 Edition of the RSMeans and dividing the Historical Cost Index for the year of the renovation by the Historical Cost Index for 2009.

iii. To determine the accumulated depreciation per bed, 2 percent per year will be used for a maximum number of 25 depreciable years.

In no case will the consideration of a Renovation Construction Project reduce the age of the facility to a number less than zero.

An example of how the cost of a renovation Construction Project would be converted to an equivalent number of replacement beds and a new base year is presented in the following table:

Example Calculation of the Impact of a Renovation on a Nursing Facility's Base Year

Ref	Data Element	Example Data	Source of Data

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A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Data
D	Year Renovation was Completed	2003	Department Data
E	Base Year Prior to Renovation	1981	Based on Initial Age Adjusted by Prior Bed Addition and Facility Renovations
F	Licensed Nursing Facility Beds	138	Department Data
G	Facility Square Footage	40,060	Department Data
H	Nursing Facility Zip Code	30442	Department Data
I	Renovation Amount	$372,662	Department Data
J	Renovation Year RS Means Cost Index	132.00	RS Means lookup based on Year Renovation Comple
K	Rate Year RS Means Cost Index	185.90	RS Means lookup based on Rate Year
L	Facility Age Index Factor	0.7101	J / K
M	Rate Year RS Means Cost per Square Foot	$141.10	RS Means lookup based on Rate Year
N	Maximum Square Feet per Bed	700	Department Criteria
O	Allowed Facility Square Footage	40,060	Lesser of G or (F x N)
P	Facility Cost Prior to Adjustments	$5,652,466	M x O
Q	RS Means Location Factor	0.77	RS Means lookup based on Zip Code (H)
R	Adjusted facility Cost	$3,090,461	P x L x Q
S	Age of Beds at Time of Renovation	22	D - E
T	Maximum Bed Replacement Years	25	Department Criteria
U	Allowed Age of Beds	22	Lesser of S or T
V	Initial Aging Depreciation Rate	2.00%	Department Criteria
W	Allowed Facility Depreciation	$1,359,803	R x U x V
X	Adjusted Bed Replacement Cost	$12,541	(R - W) / F
Y	New Bed Equivalents	29.72	I / X (but limit is F)
Z	Total Beds to be Weighed	108.28	F - Y
AA	Weighed Average of Beds	2,382.26	Z x S
AB	Base Year Age Adjustment	17.26	AA / F
AC	New Base Year	1986	D - AB (rounded)

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O. Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

P. Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002 of the Nursing Facility Manual.

Q. Other Rate Adjustments

1. Quality Improvement Initiative Program
Facilities must enroll in the Quality Improvement Program to receive the following incentives:

a. A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services will be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1 of the manual.

b. For the most recent calendar quarter for which MDS information is available, Cognitive Performance Scale (CPS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor will be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose CPS scores are moderately severe to very severe. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	4.5%

c. A quality incentive adjustment may be added to a facility's rate utilizing the following set of indicators.

1. Clinical Measures

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The source of data is the Center for Medicare and Medicaid Services (CMS) website. Each measure is worth 1 point if the facility-specific value is in excess of the statewide average.

(a) Percent of High Risk Long-Stay Residents Who Have Pressure Sores.
(b) Percent of Long-Stay Residents Who Were Physically Restrained.
(c) Percent of Long-Stay Residents Who have Moderate to Severe Pain.
(d) Percent of Short-Stay Residents Who had Moderate to Severe Pain.
(e) Percent of Residents Who Received Influenza Vaccine.
(f) Percent of Low Risk Long - Stay Residents Who Have Pressure Sores.

2. Alternative Clinical Measures

Facilities that do not generate enough data to report on the CMS website (due to not meeting the minimum number of assessments for a reporting in a quarter) will use the following measures from the My Inner View (MIV) Quality Profile. The values used from MIV Quality Profile will be compared to MIV Georgia average values for those measures. Each measure is worth 1 point if the facility-specific value is in excess of the MIV Georgia average.

(a) Chronic Care Pain - Residents without unplanned weight loss / gain
(b) PAC Pain - Residents without antipsychotic medication use
(c) High Risk Pressure Ulcer - Residents without acquired pressure ulcers.
(d) Physical Restraints - Residents without acquired restraints
(e) Vaccination: Flu - Residents without falls
(f) Low Risk Pressure Ulcer - Residents without acquired catheters

3. Non Clinical Measures:

Each measure is worth 1 point as described.

(a) Participation in the Employee Satisfaction Survey.

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(b) Most Current Family Satisfaction Survey Score for "Would you recommend this facility?" Percentage of combined responses either "excellent" or "good" to meet or exceed the state average of 85% combined
(c) Quarterly average for RNs/LVNs/LPNs Stability (retention) to meet or exceed the state average.
(d) Quarterly average for CNAs /NA Stability (retention) to meet or exceed the state average.

To qualify for a quality incentive adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of three (3) points in the following combination: One (1) point must come from clinical measures, one (1) point from the non-clinical measures, and a third point from either the clinical or non-clinical measures.

To qualify for a quality incentive adjustment equal to 2% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of six (6) points in the following combination: Three (3) points must come from the clinical measures, one (1) point from the non-clinical measures, and two (2) points from either the clinical or non-clinical measures.

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2. Other Adjustments to Rates

(a) Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

(a) Effective July 1, 2003, in order to recognize the Medicaid share of a facility's cost of paying fees for Georgia's the Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to a facility's rate. During the quarter beginning July 1, 2003, the adjustment amount will be estimated by the Division; any difference between the estimated and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.

(b) For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- All amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

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A request for a fair rental value rate increase that is the result of a Renovation Construction Project, bed addition, or replacement subsequent to July 1, 2009, must be submitted to the Department by the end of the quarter following the completion of the project. The request must be completed on a standard form for rate requests and contain documented approval of the project from the Department's General Counsel Division.

Comparisons of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment is calculated is presented on the following pages.

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Provider Name: XYZ Nursing Home

		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
Medicare UPL Rate					
Line 1	PPS rate based on Medicaid patients for each quarter [1]	157.92	149.92	149.92	149.92
Line 2	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
Line 3	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
Medicaid UPL Rate					
Line 4	Medicaid rate without provider fee [1]	89.63	86.90	85.63	90.69
Line 5	Provider Fee adjustment	9.15	9.15	9.15	9.15
Line 6	Statewide average payment for other services [1]	14.11	14.11	14.11	14.11
Line 7	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
Medicare UPL rate minus Medicaid UPL rate					
Line 8		47.40	42.01	43.28	38.22
Medicaid Patient Days					
Line 9	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
Line 10	Portion of year for each quarter	25%	25%	25%	25%
Line 11	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
Facility-Specific UPL calculation					
Line 12		261,032	231,349	238,343	210,478
Facility-Specific UPL calculation for 7-1-05 to 06-30-06					941,202

[1] Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.

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facility name: XYZ ICF-MR Nursing Home

	line description	comments	amount
1	total cost per day for SFY2004	after audit adjustments	267.70
2	capital cost per day for SFY2004	after audit adjustments	9.44
3	routine services cost per day for SFY2004	col 1 - col 2	258.26
4	projected routine service cost per day for SFY2006	col 3 x 1.06181	274.22
5	12% of projected routine service cost per day for SFY2006	col 4 x 0.12	32.91
6	Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415
7	available UPL calculation for SFY2006	col 5 x col 6	968,048