DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and State Operations, CMSO

Stan Marshburn, Interim Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

APR 23 2009

RE: WA 08-021

Dear Secretary Marshburn:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 08-021. This amendment makes technical changes to nursing facilities rates, increases the uniform statewide daily rate ceiling from $158.11 to $159.34 for State Fiscal Year (SFY) 2008 and sets the daily rate ceiling for SFY 2009 at $165.04. This amendment also adds a stipulation that the distribution of nursing facility (NF) payments between NFs will not be recalculated retroactively based on the results of an administrative or judicial review. We are pleased to inform you that Medicaid State plan amendment 08-021 is approved effective July 1, 2008. We are enclosing the HCFA-179 and the amended pages.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 08-021 is approved effective July 1, 2008. We are enclosing the HCFA-179 and the amended pages.

If you have any questions, please call Joe Fico of the National Institutional Reimbursement Team at (206) 615-2380.

Sincerely,

Jackie Garner
Acting Director
Center for Medicaid and State Operations

Enclosures

cc: Kathy Leitch, Assistant Secretary DSHS, ADSA
Doug Porter, Assistant Secretary, DSHS, HRSA

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: 08-021

2. STATE: Washington

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
July 1, 2008

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:

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 $147,345
b. FFY 2009 $443,654

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 1, 2, 3, 4, 5, 6a, 7a, 16, 18
Supplement A to Attachment 4.19-D, pages 2, 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19-D, pages 1, 2, 3, 4, 5, 6a, 7a, 16, 18
Supplement A to Attachment 4.19-D, pages 2, 3

10. SUBJECT OF AMENDMENT:

Nursing Facility 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: Exempt

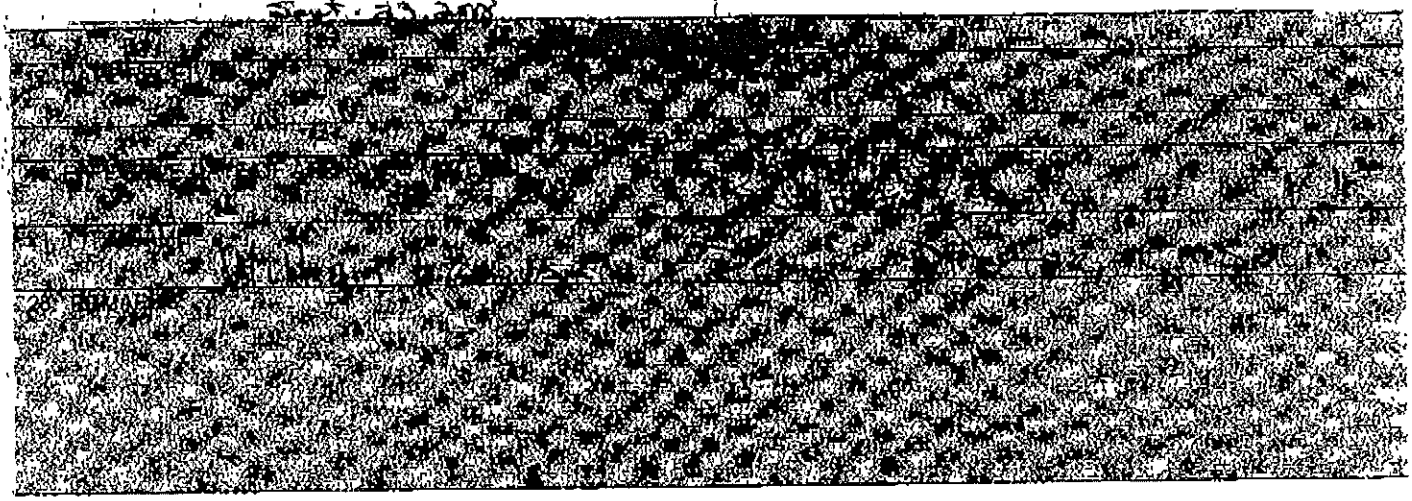
12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
Sept. 23, 2008

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
POB 5504
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504



FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section I. Introduction:

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately operated and veterans' nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

This SPA is submitted by the single state agency for Medicaid, the State of Washington Department of Social and Health Services ("department" below).

Excluded here is the payment rate methodology for nursing facilities operated by the department's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46 and chapter 34.05 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2008 as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW.

The methods and standards employed by the department to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section II. General Provisions:

Medicaid rates for nursing facility care in Washington continue to be facility specific. Prior to rate setting, nursing facilities' costs and other reported data, such as resident days, are examined, to ensure accuracy and to determine costs allowable for rate setting. Washington continues to be a state utilizing facility-specific cost data, subject to applicable limits, combined with facility-specific and regularly updated resident case mix data, to set rates.

A facility's Medicaid rate continues to represent a total of seven component rates: 1) direct care (DC), 2) therapy care (TC), 3) support services (SS), 4) operations (O), 5) variable return (VR), 6) property (P), and 7) financing allowance (FA).

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. For SFY 2008 (July 1, 2007 to June 30, 2008) the budget dial is $158.34 per resident day, and for SFY 2009 (July 1, 2008 to June 30, 2009) it is $165.04 per resident day. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

If any final order or final judgment, including a final order or final judgment resulting from an adjudicative proceeding or judicial review permitted by chapter 34.05 RCW, would result in an increase to a nursing facility's payment rate for a prior fiscal year or years, the department shall consider whether the increased rate for that facility would result in the statewide weighted average payment rate for all facilities for such fiscal year or years to be exceeded. If the increased rate would result in the statewide average payment rate for such year or years being exceeded, the department shall increase that nursing facility's payment rate to meet the final order or judgment only to the extent that it does not result in an increase to the statewide average payment rate for all facilities.

For the period from 7/1/07 through 6/30/09, the direct care, operations, support services, and therapy care rate components are rebased to the 2005 cost report.

Beginning 7/1/09, those same four rate components will be subject to automatic biennial rebasing. That is, rates for the two-year period beginning 7/1/09 will be based on the 2007cost report, and so on.

There is a hold harmless rate for qualifying facilities as of the 7/1/07 and 7/1/08 rate settings. To qualify, a facility must have combined rates in DC, SS, TH, and O for June 30, 2007 greater than its July 1, 2007 or July 1, 2008 rate adjusted for economic trends and conditions under the 2007-2009 biennial appropriations act, and must have overspent its combined DC, SS, TH, and O component rates in either 2004 or 2005. For qualifying facilities, the department compares a facility's July 1, 2007 or July 1, 2008 combined DC, SS, TC, and O rates adjusted for economic trends and conditions as specified in the 2007-2009 biennial appropriations act, with the combined DC, SS, TC, and O rates for June 30, 2007. If the combined rates for 6/30/07 are higher, then the facility will receive its 6/30/07 rates in DC, SS, TC, and O, adjusted for economic trends and conditions as specified in the 2007-2009 biennial appropriations act.

Direct care and operations component rates for July 1, 2006 are based on examined, adjusted costs and resident days from 2003 cost reports. Therapy care and support services component rates for July 1, 2006 are based on examined, adjusted costs and resident days from 1999 cost reports.

In contrast, property and financing allowance components continue to be rebased annually, utilizing each facility's cost report data for the calendar year ending six months prior to the commencement of the July 1 component rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

Effective July 1, 2006, each facility's variable return component rate allocation is set to its June 30, 2006 variable return component rate allocation.

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds:

All component rates calculated and assigned to a facility require, directly or indirectly, use of the examined number of resident days at that facility for the applicable report period. Essentially, days are divided into allowable costs for that period, to obtain facility costs expressed as per resident day amounts.

For July 1, 2001, rate setting, resident days for all facilities in all component rates continue to be subject to a minimum occupancy of 85 percent of each facility's licensed beds, regardless of how many beds are set up or in use. That is, if resident days are below this minimum for the applicable cost report period, they are increased to an imputed occupancy of 85 percent for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

If occupancy is above the minimum, the facility's actual occupancy is used. The purpose of minimum occupancy is to prevent inflated rates based on inefficient use of facility resources or failure of the facility to maintain a viable census.

Effective July 1, 2002, minimum occupancy for rate setting for all facilities will continue at 85 percent in direct care, therapy care, support services and variable return component rates. However, effective as of this date, except for facilities designated as essential community providers, minimum occupancy will be raised from 85 percent to 90 percent for calculation of operations, financing allowance and property component rates, and these components will be revised downward, if indicated, effective July 1, 2002, to reflect the higher minimum.

As noted, this increase in minimum occupancy for the affected components will not apply to essential community providers, who will continue to be subject only to an 85 percent minimum occupancy for all components on and after July 1, 2002. An "essential community provider" is defined by a minimum driving time of forty minutes to the next nearest nursing facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds (cont)

Rates in all components for all facilities on and after July 1, 2001, continue to be subject to a downward revision, if indicated, to reflect a recalculation of minimum occupancy when a facility's licensed beds are increased (or "unbanked") by converted previously de-licensed beds back to licensed status under chapter 70.38 RCW.

However, effective July 1, 2001, for all facilities except essential community providers, component rates in direct care, therapy care, support services, and variable return only continue to be subject to an upward revision, if indicted, when a facility's licensed beds are reduced (or "banked") under chapter 70.38 RCW.

Effective July 1, 2001, for all facilities except essential community providers, operations, property, and financing allowance component rates are not subject to increase when licensed beds are reduced under chapter 70.38 RCW, on or after May 25, 2001.

Effective July 1, 2001, for essential community providers, rates in all components will continue to be subject to an increase, if indicated, in response to a reduction in licensed beds under chapter 70.38 RCW, regardless of when the reduction occurs.

If a facility's affected component rates are revised downward or upward, in response to an increase or reduction, respectively, in its licensed beds under chapter 70.38 RCW, any revision is accomplished by a recalculation of minimum occupancy. The department tests the facility's resident days from the cost report use to set the rate against the facility's new licensed bed capacity.

A per resident day cost adjustment is made, reversed or modified, as may be indicated, and any rate revision is made prospectively, effective as of the date licensed bed capacity is increased or reduced.

Effective July 1, 2006, the minimum occupancy assumption is eliminated from the calculation of the direct care component rate for all facilities. This includes the calculation of the direct care component rate for facilities returning previously banked beds to active status.

Component rate allocations for direct care will be based on actual patient days, regardless of whether a facility has converted banked beds to active service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section IV: Allowable Costs (cont.)

Allowable costs for rate setting, audit and settlement are documented costs, not expressly declared unallowable or otherwise limited under chapter 74.46 RCW or 388-96 WAC, that are necessary, ordinary and related to the care of nursing facility residents. To be ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Effective July 1, 2001, facility costs of televisions in residents' rooms acquired on and after July 1, 2001, will be included in allowable costs.

Costs in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are expressly unallowable. These limits include, but are not limited to, minimum occupancy for rate setting and peer group median costs in affected cost areas and component rates.

Allowable cost limits and principles of rate setting include, in the broad sense, not only those contained in chapters 74.46 RCW and 388-96 WAC, but also those contained in all applicable state and federal laws and regulations, whether codified or uncodified, as may be pertinent to all or part of the July 1, 2001, through June 30, 2004, rate period, as may be interpreted by courts of competent jurisdiction.

The Medicaid payment rate system for the State of Washington does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered or reimbursed in any payment period. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with state and federal laws, not to reimburse costs, however defined, of a provider.

Section V. Adjustments to Payment Rates for Economic Trends and Conditions:

Effective July 1, 2002, all facilities having their direct care component rates established on case mix principles promulgated in law and regulation, receive a 2.3 percent upward adjustment for economic trends and conditions to their direct care component rates. Any facilities continuing to receive a "hold harmless" direct care component rate as of July 1, 2002, receive no upward adjustment for economic trends and conditions to their direct care component rates; however, the hold harmless provision is terminated effective July 1, 2002, also, so unless this scheduled change to the methodology is eliminated for some facilities, all facilities should receive the 2.3 upward adjustment for economic trends and conditions effective July 1, 2002.

Effective July 1, 2005, all facilities receive a 1.3 percent upward adjustment for economic trends and conditions to their direct care, therapy care, support services, and operations component rates established in accordance with chapter 74.46 RCW and an additional 1.3 percent upward adjustment effective July 1, 2006.

Effective July 1, 2008, all facilities receive a 1.99 percent upward adjustment for economic trends and conditions to their direct care, support services, therapy care, and operations component rates established in accordance with chapter 74.46 RCW.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

Index is a number indicating intensity of need for services by a resident population, or group within a population.

Effective July 1, 2008, the facility average case mix index will be used throughout the applicable cost-rebasing period. Also, when establishing direct care component rates, the department will use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations.

Effective July 1, 2008, a "low-wage worker add-on" of $1.57 per Medicaid resident day is provided to those facilities electing to accept it, for the purpose of increasing wages and benefits, and/or staffing levels, in lower-paid job categories.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

A "hold harmless" provision is granted to VLPs. For a VLP, the sum of the facility's direct care and operations component rates calculated as of July 1, 2006 will be compared to the sum of those same two component rates as of June 30, 2006. If the sum as of July 1, 2006 is lower than the sum as of June 30, 2006, then the VLP will continue to receive the direct care and operations component rate allocations calculated as of June 30, 2006. In setting economic trends and conditions adjustment factors for the direct care and operations components rate allocations, the Legislature may define different adjustment factors for vital local providers whose rates are set equal to their June 30, 2006 rates. The VLP designation was terminated effective July 1, 2007.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIV. Adjustments to Prospective Rates other than for Economic Trends and Conditions, Changes in Case Mix, Fluctuation in Licensed Beds or One-Time Specific Authorizations:

The department may grant prospective rate adjustment to fund new requirements imposed by the federal government or by the department, if the department determines a rate increase is necessary in order to implement the new requirement.

Rates may be revised prospectively to fund capitalized facility additions and replacements meeting all applicable conditions, such as certificate of need or exemption from certificate of need, and a certificate of capital authorization from the department, if required for the project.

Rates may be adjusted prospectively and retrospectively to correct errors or omissions on the part of the department or the facility, or to implement the final result of a provider appeal if needed, or to fund the cost of placing a nursing facility in receivership or to aid the receiver in correcting deficiencies.

Rates may be revised to reflect an increase in real property taxes resulting from a facility building construction, expansion, renovation or replacement project, but only up to the median cost limit in the affected component, the operations component rate. Also, to qualify, the project must require the purchase of additional land, must have been completed on or after July 1, 1997, and the rate increase cannot commence prior to the effective date of the tax increase.

Section XV. Rates for Swing Bed Hospitals:

Rates for swing bed hospitals providing nursing facility care to Medicaid eligible residents continue to be set for each SFY (July 1 through June 30) at the approximate, weighted statewide average total paid to Medicaid nursing facilities during the preceding SFY. So the Medicaid swing bed rate effective July 1, 2001, is derived from the average nursing facility Medicaid rate for SFY 2000.

The average rate comprising the swing bed rate for July 1, 2001, is computed by first multiplying each nursing facility's approximate total rate on July 1 of the preceding fiscal year (July 1, 2000) by the facility's approximate number of Medicaid resident days for the month of July during the preceding SFY (July 2000), which yields an approximate total Medicaid payment for each facility for that month.

Total payments to all Medicaid facilities for July of the preceding SFY are added which yields the approximate total payment to all facilities for that month, and then the total is divided by statewide Medicaid resident days for the same month to derive a weighted average for all facilities.

The average for July 2008 was $158.10 per resident day, which comprises the swing bed rate for the July 1, 2008 to June 30, 2009 rate period. The same methodology is followed annually to reset the swing bed rate, effective July 1 of each year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XVI. 1997 Balanced Budget Act, Section 4711 -- Public Process for Changes to Nursing Facility Medicaid Payment Rates (cont.)

(4) After receiving and considering all comments, if the department decides to move ahead with a change or changes to its nursing facility payment rate methodologies, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated rates, final rate determination methodologies and justifications. Publication shall be: (a) in the Washington State Register; or (b) in The Seattle Times and The Spokesman Review newspapers. Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication in the Register has occurred or publication in both designated newspapers has occurred. The department shall not be authorized to delay implementation of changes, or to alter, ignore or violate requirements of state or federal laws in response to public process comments.

Section XVII. Proportionate Share Payments for Nursing Facilities Operated by Public Hospital Districts:

The following is effective for the period from July 1, 2005 to June 30, 2009:

An aggregate Upper Payment Limit is calculated each state fiscal year for supplemental payments to eligible providers of Medicaid nursing facility services. Eligible providers are public hospital districts that operate nursing facilities.

The public hospital districts are responsible for certifying costs eligible for the supplemental payments, which shall not exceed the maximum allowable under federal rules. The state will ensure that the public hospital districts certify these expenditures in accordance with 42 CFR 433.51.

The payments to public hospital districts shall be supplemental to, and shall not in any way offset or reduce, the normal Medicaid nursing facility payments calculated and provided in accordance with part E of Ch. 74.46 RCW. Costs to improve access to health care at nursing facilities operated by public hospital districts that are otherwise allowable for rate-setting and for settlement against payments made under Ch. 74.46 RCW shall not be disallowed solely because such costs have been paid by revenues retained by the nursing facility from these supplemental payments.

The supplemental payments are limited to the difference between Medicaid routine costs incurred by the public hospital district-operated nursing facilities and the total Medicaid routine payments received by the facility during the rate year in which the supplemental payments will be claimed. The process for identifying such eligible incurred Medicaid cost is defined in Supplement A to Attachment 4.19-D, Part 1. The Medicare upper payment limit analysis shall be performed prior to making the supplemental payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (cont)

incurred by the NF and Medicaid payment received by the NF is $18 per day, the nursing facility will receive $18 per day. The aggregate amount is redistributed evenly to the facilities up to their specific cost limits.

The payments for state fiscal year 2008 will be based on the cost information from the 2006 as filed Medicare 2552-96 cost report. The NF routine cost per patient day amount from worksheet D-1 will be multiplied by the 2004 Medicaid days from the State's MMIS payment system to compute Medicaid costs. The 2006 Medicaid base NF routine payments will be subtracted from the computed Medicaid costs to determine the NF's maximum supplemental payment amount. An interim reconciliation will be performed with the 2008 as filed 2552-96 cost report and a final reconciliation will be performed with the 2008 intermediary audited 2552-96 cost report.

The payments for state fiscal year 2009 will be based on the cost information from the 2007 as filed Medicare 2552-96 cost report. The NF routine cost per patient day amount from worksheet D-1 will be multiplied by the 2007 Medicaid days from the State's MMIS payment system to compute the Medicaid costs. The 2007 Medicaid base NF routine payments will be subtracted from the computed Medicaid costs to determine the NF's maximum supplemental payment amount. An interim reconciliation will be performed with the 2009 as filed 2552-96 cost report and a final reconciliation will be performed with the 2009 intermediary audited 2552-96 cost report.

With both the interim and final reconciliations, there may be a recoupment if an NF's Medicaid costs are less than what it was paid. If a hospital's Medicaid costs are higher than what it was paid, then it could receive more money as long as the aggregate UPL is not exceeded. The Medicaid costs will be determined by multiplying the per diem costs by the Medicaid days. The Medicaid days will be reconciled to Washington State DSHS payment records for the cost reporting period.

Medicare 2540-96 Cost Report for Skilled Nursing Facilities Operated by Public Hospital Districts in Washington State

The process is essentially the same as for the Medicare 2552-96 cost report, although the line number references on the cost report schedules are not the same.

The schedule references where the nursing home costs and total days are found on the 2540-96 cost reports are as follows:

Skilled Nursing Facility costs are found on Schedule B Part I, line 16, column 18.

Skilled Nursing total days are found on Schedule S-3 Part I, line 1, column 7.

Routine cost per patient day is found on Schedule D-1 Part I, line 16.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (cont)

The 2008 NH UPL payment is based on the 2006 cost information from the 2540-96 as filed. There will be an interim reconciliation with the 2008 as filed cost report 2540-96 and a final reconciliation with the intermediary audited 2008 cost report 2540-96. The UPL payment will be adjusted using the same method as used with the 2552-96 cost report.

The 2009 NH UPL payment is based on the 2007 cost information from the 2540-96 as filed. There will be an interim reconciliation with the 2009 as filed cost report 2540-96 and a final reconciliation with the intermediary audited 2009 cost report 2540-96. The UPL payment will be adjusted using the same method as used with the 2552-96 cost report.