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HOUSE BILL 2457

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State of Washington

57th Legislature

2002 Regular Session

By Representatives Sommers and Lovick; by request of Department of Social and Health Services

Read first time 01/17/2002. Referred to Committee on Appropriations.

1 AN ACT Relating to the nursing facility medicaid payment system;  
2 amending RCW 74.46.020, 74.46.165, 74.46.310, 74.46.320, 74.46.330,  
3 74.46.350, 74.46.410, 74.46.431, 74.46.435, 74.46.437, 74.46.439,  
4 74.46.506, 74.46.511, 74.46.515, and 74.46.521; and repealing RCW  
5 74.46.433.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 **Sec. 1.** RCW 74.46.020 and 2001 1st sp.s. c 8 s 1 are each amended  
8 to read as follows:

9 Unless the context clearly requires otherwise, the definitions in  
10 this section apply throughout this chapter.

11 (1) "Accrual method of accounting" means a method of accounting in  
12 which revenues are reported in the period when they are earned,  
13 regardless of when they are collected, and expenses are reported in the  
14 period in which they are incurred, regardless of when they are paid.

15 (2) "Appraisal" means the process of estimating the fair market  
16 value or reconstructing the historical cost of an asset acquired in a  
17 past period as performed by a professionally designated real estate  
18 appraiser with no pecuniary interest in the property to be appraised.  
19 It includes a systematic, analytic determination and the recording and

1 analyzing of property facts, rights, investments, and values based on  
2 a personal inspection and inventory of the property.

3 (3) "Arm's-length transaction" means a transaction resulting from  
4 good-faith bargaining between a buyer and seller who are not related  
5 organizations and have adverse positions in the market place. Sales or  
6 exchanges of nursing home facilities among two or more parties in which  
7 all parties subsequently continue to own one or more of the facilities  
8 involved in the transactions shall not be considered as arm's-length  
9 transactions for purposes of this chapter. Sale of a nursing home  
10 facility which is subsequently leased back to the seller within five  
11 years of the date of sale shall not be considered as an arm's-length  
12 transaction for purposes of this chapter.

13 (4) "Assets" means economic resources of the contractor, recognized  
14 and measured in conformity with generally accepted accounting  
15 principles.

16 (5) "Audit" or "department audit" means an examination of the  
17 records of a nursing facility participating in the medicaid payment  
18 system, including but not limited to: The contractor's financial and  
19 statistical records, cost reports and all supporting documentation and  
20 schedules, receivables, and resident trust funds, to be performed as  
21 deemed necessary by the department and according to department rule.

22 (6) "Bad debts" means amounts considered to be uncollectible from  
23 accounts and notes receivable.

24 (7) "Beneficial owner" means:

25 (a) Any person who, directly or indirectly, through any contract,  
26 arrangement, understanding, relationship, or otherwise has or shares:

27 (i) Voting power which includes the power to vote, or to direct the  
28 voting of such ownership interest; and/or

29 (ii) Investment power which includes the power to dispose, or to  
30 direct the disposition of such ownership interest;

31 (b) Any person who, directly or indirectly, creates or uses a  
32 trust, proxy, power of attorney, pooling arrangement, or any other  
33 contract, arrangement, or device with the purpose or effect of  
34 divesting himself or herself of beneficial ownership of an ownership  
35 interest or preventing the vesting of such beneficial ownership as part  
36 of a plan or scheme to evade the reporting requirements of this  
37 chapter;

1 (c) Any person who, subject to (b) of this subsection, has the  
2 right to acquire beneficial ownership of such ownership interest within  
3 sixty days, including but not limited to any right to acquire:

4 (i) Through the exercise of any option, warrant, or right;

5 (ii) Through the conversion of an ownership interest;

6 (iii) Pursuant to the power to revoke a trust, discretionary  
7 account, or similar arrangement; or

8 (iv) Pursuant to the automatic termination of a trust,  
9 discretionary account, or similar arrangement;

10 except that, any person who acquires an ownership interest or power  
11 specified in (c)(i), (ii), or (iii) of this subsection with the purpose  
12 or effect of changing or influencing the control of the contractor, or  
13 in connection with or as a participant in any transaction having such  
14 purpose or effect, immediately upon such acquisition shall be deemed to  
15 be the beneficial owner of the ownership interest which may be acquired  
16 through the exercise or conversion of such ownership interest or power;

17 (d) Any person who in the ordinary course of business is a pledgee  
18 of ownership interest under a written pledge agreement shall not be  
19 deemed to be the beneficial owner of such pledged ownership interest  
20 until the pledgee has taken all formal steps necessary which are  
21 required to declare a default and determines that the power to vote or  
22 to direct the vote or to dispose or to direct the disposition of such  
23 pledged ownership interest will be exercised; except that:

24 (i) The pledgee agreement is bona fide and was not entered into  
25 with the purpose nor with the effect of changing or influencing the  
26 control of the contractor, nor in connection with any transaction  
27 having such purpose or effect, including persons meeting the conditions  
28 set forth in (b) of this subsection; and

29 (ii) The pledgee agreement, prior to default, does not grant to the  
30 pledgee:

31 (A) The power to vote or to direct the vote of the pledged  
32 ownership interest; or

33 (B) The power to dispose or direct the disposition of the pledged  
34 ownership interest, other than the grant of such power(s) pursuant to  
35 a pledge agreement under which credit is extended and in which the  
36 pledgee is a broker or dealer.

37 (8) "Capitalization" means the recording of an expenditure as an  
38 asset.

1 (9) "Case mix" means a measure of the intensity of care and  
2 services needed by the residents of a nursing facility or a group of  
3 residents in the facility.

4 (10) "Case mix index" means a number representing the average case  
5 mix of a nursing facility.

6 (11) "Case mix weight" means a numeric score that identifies the  
7 relative resources used by a particular group of a nursing facility's  
8 residents.

9 (12) "Certificate of capital authorization" means a certification  
10 from the department for an allocation from the biennial capital  
11 financing authorization for all new or replacement building  
12 construction, or for major renovation projects, receiving a certificate  
13 of need or a certificate of need exemption under chapter 70.38 RCW  
14 after July 1, 2001.

15 (13) "Contractor" means a person or entity licensed under chapter  
16 18.51 RCW to operate a medicare and medicaid certified nursing  
17 facility, responsible for operational decisions, and contracting with  
18 the department to provide services to medicaid recipients residing in  
19 the facility.

20 (14) "Default case" means no initial assessment has been completed  
21 for a resident and transmitted to the department by the cut-off date,  
22 or an assessment is otherwise past due for the resident, under state  
23 and federal requirements.

24 (15) "Department" means the department of social and health  
25 services (DSHS) and its employees.

26 (16) "Depreciation" means the systematic distribution of the cost  
27 or other basis of tangible assets, less salvage, over the estimated  
28 useful life of the assets.

29 (17) "Direct care" means nursing care and related care provided to  
30 nursing facility residents. Therapy care shall not be considered part  
31 of direct care.

32 (18) "Direct care supplies" means medical, pharmaceutical, and  
33 other supplies required for the direct care of a nursing facility's  
34 residents.

35 (19) "Entity" means an individual, partnership, corporation,  
36 limited liability company, or any other association of individuals  
37 capable of entering enforceable contracts.

38 (20) "Equity" means the net book value of all tangible and  
39 intangible assets less the recorded value of all liabilities, as

1 recognized and measured in conformity with generally accepted  
2 accounting principles.

3 (21) "Essential community provider" means a facility which is the  
4 only nursing facility within a commuting distance radius of at least  
5 forty minutes duration, traveling by automobile.

6 (22) "Facility" or "nursing facility" means a nursing home licensed  
7 in accordance with chapter 18.51 RCW, excepting nursing homes certified  
8 as institutions for mental diseases, or that portion of a multiservice  
9 facility licensed as a nursing home, or that portion of a hospital  
10 licensed in accordance with chapter 70.41 RCW which operates as a  
11 nursing home.

12 (23) "Fair market value" means the replacement cost of an asset  
13 less observed physical depreciation on the date for which the market  
14 value is being determined.

15 (24) "Financial statements" means statements prepared and presented  
16 in conformity with generally accepted accounting principles including,  
17 but not limited to, balance sheet, statement of operations, statement  
18 of changes in financial position, and related notes.

19 (25) "Generally accepted accounting principles" means accounting  
20 principles approved by the financial accounting standards board (FASB).

21 (26) "Goodwill" means the excess of the price paid for a nursing  
22 facility business over the fair market value of all net identifiable  
23 tangible and intangible assets acquired, as measured in accordance with  
24 generally accepted accounting principles.

25 (27) "Grouper" means a computer software product that groups  
26 individual nursing facility residents into case mix classification  
27 groups based on specific resident assessment data and computer logic.

28 (28) "High labor-cost county" means an urban county in which the  
29 median allowable facility cost per case mix unit is more than ten  
30 percent higher than the median allowable facility cost per case mix  
31 unit among all other urban counties, excluding that county.

32 (29) "Historical cost" means the actual cost incurred in acquiring  
33 and preparing an asset for use, including feasibility studies,  
34 architect's fees, and engineering studies.

35 (30) "Home and central office costs" means costs that are incurred  
36 in the support and operation of a home and central office. Home and  
37 central office costs include centralized services that are performed in  
38 support of a nursing facility. The department may exclude from this  
39 definition costs that are nonduplicative, documented, ordinary,

1 necessary, and related to the provision of care services to authorized  
2 patients.

3 (31) "Imprest fund" means a fund which is regularly replenished in  
4 exactly the amount expended from it.

5 (32) "Joint facility costs" means any costs which represent  
6 resources which benefit more than one facility, or one facility and any  
7 other entity.

8 (33) "Lease agreement" means a contract between two parties for the  
9 possession and use of real or personal property or assets for a  
10 specified period of time in exchange for specified periodic payments.  
11 Elimination (due to any cause other than death or divorce) or addition  
12 of any party to the contract, expiration, or modification of any lease  
13 term in effect on January 1, 1980, or termination of the lease by  
14 either party by any means shall constitute a termination of the lease  
15 agreement. An extension or renewal of a lease agreement, whether or  
16 not pursuant to a renewal provision in the lease agreement, shall be  
17 considered a new lease agreement. A strictly formal change in the  
18 lease agreement which modifies the method, frequency, or manner in  
19 which the lease payments are made, but does not increase the total  
20 lease payment obligation of the lessee, shall not be considered  
21 modification of a lease term.

22 (34) "Medical care program" or "medicaid program" means medical  
23 assistance, including nursing care, provided under RCW 74.09.500 or  
24 authorized state medical care services.

25 (35) "Medical care recipient," "medicaid recipient," or "recipient"  
26 means an individual determined eligible by the department for the  
27 services provided under chapter 74.09 RCW.

28 (36) "Minimum data set" means the overall data component of the  
29 resident assessment instrument, indicating the strengths, needs, and  
30 preferences of an individual nursing facility resident.

31 (37) "Net book value" means the historical cost of an asset less  
32 accumulated depreciation.

33 (38) "Net invested funds" means the net book value of tangible  
34 fixed assets employed by a contractor to provide services under the  
35 medical care program, including (~~land~~) buildings(~~(~~) and equipment,  
36 and excluding land and land improvements, as recognized and measured in  
37 conformity with generally accepted accounting principles. The  
38 allowable net book value of buildings and building improvements is  
39 eighty percent of their actual net book value.

1 (39) "Nonurban county" means a county which is not located in a  
2 metropolitan statistical area as determined and defined by the United  
3 States office of management and budget or other appropriate agency or  
4 office of the federal government.

5 (40) "Operating lease" means a lease under which rental or lease  
6 expenses are included in current expenses in accordance with generally  
7 accepted accounting principles.

8 (41) "Owner" means a sole proprietor, general or limited partners,  
9 members of a limited liability company, and beneficial interest holders  
10 of five percent or more of a corporation's outstanding stock.

11 (42) "Ownership interest" means all interests beneficially owned by  
12 a person, calculated in the aggregate, regardless of the form which  
13 such beneficial ownership takes.

14 (43) "Patient day" or "resident day" means a calendar day of care  
15 provided to a nursing facility resident, regardless of payment source,  
16 which will include the day of admission and exclude the day of  
17 discharge; except that, when admission and discharge occur on the same  
18 day, one day of care shall be deemed to exist. A "medicaid day" or  
19 "recipient day" means a calendar day of care provided to a medicaid  
20 recipient determined eligible by the department for services provided  
21 under chapter 74.09 RCW, subject to the same conditions regarding  
22 admission and discharge applicable to a patient day or resident day of  
23 care.

24 (44) "Professionally designated real estate appraiser" means an  
25 individual who is regularly engaged in the business of providing real  
26 estate valuation services for a fee, and who is deemed qualified by a  
27 nationally recognized real estate appraisal educational organization on  
28 the basis of extensive practical appraisal experience, including the  
29 writing of real estate valuation reports as well as the passing of  
30 written examinations on valuation practice and theory, and who by  
31 virtue of membership in such organization is required to subscribe and  
32 adhere to certain standards of professional practice as such  
33 organization prescribes.

34 (45) "Qualified therapist" means:

35 (a) A mental health professional as defined by chapter 71.05 RCW;

36 (b) A mental retardation professional who is a therapist approved  
37 by the department who has had specialized training or one year's  
38 experience in treating or working with the mentally retarded or  
39 developmentally disabled;

1 (c) A speech pathologist who is eligible for a certificate of  
2 clinical competence in speech pathology or who has the equivalent  
3 education and clinical experience;

4 (d) A physical therapist as defined by chapter 18.74 RCW;

5 (e) An occupational therapist who is a graduate of a program in  
6 occupational therapy, or who has the equivalent of such education or  
7 training; and

8 (f) A respiratory care practitioner certified under chapter 18.89  
9 RCW.

10 (46) "Rate" or "rate allocation" means the medicaid per-patient-day  
11 payment amount for medicaid patients calculated in accordance with the  
12 allocation methodology set forth in part E of this chapter.

13 (47) "Real property," whether leased or owned by the contractor,  
14 means the building, allowable land, land improvements, and building  
15 improvements associated with a nursing facility.

16 (48) "Rebased rate" or "cost-rebased rate" means a facility-  
17 specific component rate assigned to a nursing facility for a particular  
18 rate period established on desk-reviewed, adjusted costs reported for  
19 that facility covering at least six months of a prior calendar year  
20 designated as a year to be used for cost-rebasing payment rate  
21 allocations under the provisions of this chapter.

22 (49) "Records" means those data supporting all financial statements  
23 and cost reports including, but not limited to, all general and  
24 subsidiary ledgers, books of original entry, and transaction  
25 documentation, however such data are maintained.

26 (50) "Related organization" means an entity which is under common  
27 ownership and/or control with, or has control of, or is controlled by,  
28 the contractor.

29 (a) "Common ownership" exists when an entity is the beneficial  
30 owner of five percent or more ownership interest in the contractor and  
31 any other entity.

32 (b) "Control" exists where an entity has the power, directly or  
33 indirectly, significantly to influence or direct the actions or  
34 policies of an organization or institution, whether or not it is  
35 legally enforceable and however it is exercisable or exercised.

36 (51) "Related care" means only those services that are directly  
37 related to providing direct care to nursing facility residents. These  
38 services include, but are not limited to, nursing direction and



1 supervision, medical direction, medical records, pharmacy services,  
2 activities, and social services.

3 (52) "Resident assessment instrument," including federally approved  
4 modifications for use in this state, means a federally mandated,  
5 comprehensive nursing facility resident care planning and assessment  
6 tool, consisting of the minimum data set and resident assessment  
7 protocols.

8 (53) "Resident assessment protocols" means those components of the  
9 resident assessment instrument that use the minimum data set to trigger  
10 or flag a resident's potential problems and risk areas.

11 (54) "Resource utilization groups" means a case mix classification  
12 system that identifies relative resources needed to care for an  
13 individual nursing facility resident.

14 (55) "Restricted fund" means those funds the principal and/or  
15 income of which is limited by agreement with or direction of the donor  
16 to a specific purpose.

17 (56) "Secretary" means the secretary of the department of social  
18 and health services.

19 (57) "Support services" means food, food preparation, dietary,  
20 housekeeping, and laundry services provided to nursing facility  
21 residents.

22 (58) "Therapy care" means those services required by a nursing  
23 facility resident's comprehensive assessment and plan of care, that are  
24 provided by qualified therapists, or support personnel under their  
25 supervision, including related costs as designated by the department.

26 (59) "Title XIX" or "medicaid" means the 1965 amendments to the  
27 social security act, P.L. 89-07, as amended and the medicaid program  
28 administered by the department.

29 (60) "Urban county" means a county which is located in a  
30 metropolitan statistical area as determined and defined by the United  
31 States office of management and budget or other appropriate agency or  
32 office of the federal government.

33 **Sec. 2.** RCW 74.46.165 and 2001 1st sp.s. c 8 s 2 are each amended  
34 to read as follows:

35 (1) Contractors shall be required to submit with each annual  
36 nursing facility cost report a proposed settlement report showing  
37 underspending or overspending in each component rate during the cost  
38 report year on a per-resident day basis. The department shall accept

1 or reject the proposed settlement report, explain any adjustments, and  
2 issue a revised settlement report if needed.

3 (2) Contractors shall not be required to refund payments made in  
4 the operations, (~~(variable return,)~~) property, and financing allowance  
5 component rates in excess of the adjusted costs of providing services  
6 corresponding to these components.

7 (3) The facility will return to the department any overpayment  
8 amounts in each of the direct care, therapy care, and support services  
9 rate components that the department identifies following the audit and  
10 settlement procedures as described in this chapter(~~(, provided that the~~  
11 ~~contractor may retain any overpayment that does not exceed 1.0% of the~~  
12 ~~facility's direct care, therapy care, and support services component~~  
13 ~~rate. However, no overpayments may be retained in a cost center to~~  
14 ~~which savings have been shifted to cover a deficit, as provided in~~  
15 ~~subsection (4) of this section. Facilities that are not in substantial~~  
16 ~~compliance for more than ninety days, and facilities that provide~~  
17 ~~substandard quality of care at any time, during the period for which~~  
18 ~~settlement is being calculated, will not be allowed to retain any~~  
19 ~~amount of overpayment in the facility's direct care, therapy care, and~~  
20 ~~support services component rate. The terms "not in substantial~~  
21 ~~compliance" and "substandard quality of care" shall be defined by~~  
22 ~~federal survey regulations)).~~

23 (4) Determination of unused rate funds, including the amounts of  
24 direct care, therapy care, and support services to be recovered, shall  
25 be done separately for each component rate, and, except as otherwise  
26 provided in this subsection, neither costs nor rate payments shall be  
27 shifted from one component rate or corresponding service area to  
28 another in determining the degree of underspending or recovery, if any.  
29 In computing a preliminary or final settlement, savings in the support  
30 services cost center shall be shifted to cover a deficit in the direct  
31 care or therapy cost centers up to the amount of any savings, but no  
32 more than twenty percent of the support services component rate may be  
33 shifted. In computing a preliminary or final settlement, savings in  
34 direct care and therapy care may be shifted to cover a deficit in these  
35 two cost centers up to the amount of savings in each, regardless of the  
36 percentage of either component rate shifted. (~~(Contractor retained~~  
37 ~~overpayments up to one percent of direct care, therapy care, and~~  
38 ~~support services rate components, as authorized in subsection (3) of~~

1 ~~this section, shall be calculated and applied after all shifting is~~  
2 ~~completed.))~~

3 (5) Total and component payment rates assigned to a nursing  
4 facility, as calculated and revised, if needed, under the provisions of  
5 this chapter and those rules as the department may adopt, shall  
6 represent the maximum payment for nursing facility services rendered to  
7 medicaid recipients for the period the rates are in effect. No  
8 increase in payment to a contractor shall result from spending above  
9 the total payment rate or in any rate component.

10 (6) RCW 74.46.150 through 74.46.180, and rules adopted by the  
11 department prior to July 1, 1998, shall continue to govern the medicaid  
12 settlement process for periods prior to October 1, 1998, as if these  
13 statutes and rules remained in full force and effect.

14 (7) For calendar year 1998, the department shall calculate split  
15 settlements covering January 1, 1998, through September 30, 1998, and  
16 October 1, 1998, through December 31, 1998. For the period beginning  
17 October 1, 1998, rules specified in this chapter shall apply. The  
18 department shall, by rule, determine the division of calendar year 1998  
19 adjusted costs for settlement purposes.

20 **Sec. 3.** RCW 74.46.310 and 1983 1st ex.s. c 67 s 16 are each  
21 amended to read as follows:

22 The following costs shall be capitalized:

23 (1) Expenses for facilities or equipment with historical cost in  
24 excess of (~~seven~~) two thousand five hundred (~~fifty~~) dollars per  
25 unit and a useful life of more than one year from the date of purchase;  
26 and

27 (2) Expenses for equipment with historical cost of (~~seven~~) two  
28 thousand five hundred (~~fifty~~) dollars or less per unit if either:

29 (a) The item was acquired in a group purchase where the total cost  
30 exceeded (~~seven~~) two thousand five hundred (~~fifty~~) dollars; or

31 (b) The item was part of the initial stock of the facility.

32 (3) Dollar limits in this section may be adjusted for economic  
33 trends and conditions by the department as established by rule (~~and~~  
34 ~~regulation~~)).

35 **Sec. 4.** RCW 74.46.320 and 1980 c 177 s 32 are each amended to read  
36 as follows:

1       (1) Depreciation expense on depreciable assets which are required  
2 in the regular course of providing patient care will be an allowable  
3 cost. ((It)) The depreciation expense shall be computed using the  
4 depreciation base, lives, and methods specified in this chapter.

5       (2) Effective July 1, 2002, the department will:

6       (a) Not allow depreciation expense for land improvements; and

7       (b) Limit allowable depreciation to eighty percent of the total  
8 depreciation expense on building and building improvements.

9       **Sec. 5.** RCW 74.46.330 and 1980 c 177 s 33 are each amended to read  
10 as follows:

11       Tangible assets of the following types in which a contractor has an  
12 interest through ownership or leasing are subject to depreciation:

13       (1) Building - the basic structure or shell and additions thereto;

14       (2) Building fixed equipment - attachments to buildings, including,  
15 but not limited to, wiring, electrical fixtures, plumbing, elevators,  
16 heating system, and air conditioning system. The general  
17 characteristics of this equipment are:

18       (a) Affixed to the building and not subject to transfer; and

19       (b) A fairly long life, but shorter than the life of the building  
20 to which affixed;

21       (3) Major movable equipment including, but not limited to, beds,  
22 wheelchairs, desks, and x-ray machines. The general characteristics of  
23 this equipment are:

24       (a) A relatively fixed location in the building;

25       (b) Capable of being moved as distinguished from building  
26 equipment;

27       (c) A unit cost sufficient to justify ledger control;

28       (d) Sufficient size and identity to make control feasible by means  
29 of identification tags; and

30       (e) A minimum life greater than one year;

31       (4) Minor equipment including, but not limited to, waste baskets,  
32 bed pans, syringes, catheters, silverware, mops, and buckets which are  
33 properly capitalized. No depreciation shall be taken on items which  
34 are not properly capitalized as directed in RCW 74.46.310. The general  
35 characteristics of minor equipment are:

36       (a) In general, no fixed location and subject to use by various  
37 departments;

38       (b) Small in size and unit cost;

- 1 (c) Subject to inventory control;  
2 (d) Large number in use; and  
3 (e) Generally, a useful life of one to three years;  
4 (5) (~~Land improvements including, but not limited to, paving,~~  
5 ~~tunnels, underpasses, on-site sewer and water lines, parking lots,~~  
6 ~~shrubbery, fences, and walls where replacement is the responsibility of~~  
7 ~~the contractor; and~~  
8 (6)) Leasehold improvements - betterments and additions made by  
9 the lessee to the leased property, except those made to land  
10 improvements, which become the property of the lessor after the  
11 expiration of the lease.

12 **Sec. 6.** RCW 74.46.350 and 1999 c 353 s 13 are each amended to read  
13 as follows:

14 (1) Buildings(~~(, land)~~) and building improvements((,)) subject to  
15 the limit imposed by RCW 74.46.320 and fixed equipment shall be  
16 depreciated using the straight-line method of depreciation. For new or  
17 replacement building construction or for major renovations, either of  
18 which receives certificate of need approval or certificate of need  
19 exemption under chapter 70.38 RCW on or after July 1, 1999, the number  
20 of years used to depreciate fixed equipment shall be the same number of  
21 years as the life of the building to which it is affixed. Major-minor  
22 equipment shall be depreciated using either the straight-line method,  
23 the sum-of-the-years' digits method, or declining balance method not to  
24 exceed one hundred fifty percent of the straight line rate.  
25 Contractors who have elected to take either the sum-of-the-years'  
26 digits method or the declining balance method of depreciation on major-  
27 minor equipment may change to the straight-line method without  
28 permission of the department.

29 (2) The annual provision for depreciation shall be reduced by the  
30 portion allocable to use of the asset for purposes which are neither  
31 necessary nor related to patient care.

32 (3) No further depreciation shall be claimed after an asset has  
33 been fully depreciated unless a new depreciation base is established  
34 pursuant to RCW 74.46.360.

35 **Sec. 7.** RCW 74.46.410 and 2001 1st sp.s. c 8 s 3 are each amended  
36 to read as follows:

1 (1) Costs will be unallowable if they are not documented,  
2 necessary, ordinary, and related to the provision of care services to  
3 authorized patients.

4 (2) Unallowable costs include, but are not limited to, the  
5 following:

6 (a) Costs of items or services not covered by the medical care  
7 program. Costs of such items or services will be unallowable even if  
8 they are indirectly reimbursed by the department as the result of an  
9 authorized reduction in patient contribution;

10 (b) Costs of services and items provided to recipients which are  
11 covered by the department's medical care program but not included in  
12 the medicaid per-resident day payment rate established by the  
13 department under this chapter;

14 (c) Costs associated with a capital expenditure subject to section  
15 1122 approval (part 100, Title 42 C.F.R.) if the department found it  
16 was not consistent with applicable standards, criteria, or plans. If  
17 the department was not given timely notice of a proposed capital  
18 expenditure, all associated costs will be unallowable up to the date  
19 they are determined to be reimbursable under applicable federal  
20 regulations;

21 (d) Costs associated with a construction or acquisition project  
22 requiring certificate of need approval, or exemption from the  
23 requirements for certificate of need for the replacement of existing  
24 nursing home beds, pursuant to chapter 70.38 RCW if such approval or  
25 exemption was not obtained;

26 (e) Interest costs other than those provided by RCW 74.46.290 on  
27 and after January 1, 1985;

28 (f) Salaries or other compensation of owners, officers, directors,  
29 stockholders, partners, principals, participants, and others associated  
30 with the contractor or its home office, including all board of  
31 directors' fees for any purpose, except reasonable compensation paid  
32 for service related to patient care;

33 (g) Costs in excess of limits or in violation of principles set  
34 forth in this chapter;

35 (h) Costs resulting from transactions or the application of  
36 accounting methods which circumvent the principles of the payment  
37 system set forth in this chapter;

38 (i) Costs applicable to services, facilities, and supplies  
39 furnished by a related organization in excess of the lower of the cost

1 to the related organization or the price of comparable services,  
2 facilities, or supplies purchased elsewhere;

3 (j) Bad debts of non-Title XIX recipients. Bad debts of Title XIX  
4 recipients are allowable if the debt is related to covered services, it  
5 arises from the recipient's required contribution toward the cost of  
6 care, the provider can establish that reasonable collection efforts  
7 were made, the debt was actually uncollectible when claimed as  
8 worthless, and sound business judgment established that there was no  
9 likelihood of recovery at any time in the future;

10 (k) Charity and courtesy allowances;

11 (l) Cash, assessments, or other contributions, excluding dues, to  
12 charitable organizations, professional organizations, trade  
13 associations, or political parties, and costs incurred to improve  
14 community or public relations;

15 (m) Vending machine expenses;

16 (n) Expenses for barber or beautician services not included in  
17 routine care;

18 (o) Funeral and burial expenses;

19 (p) Costs of gift shop operations and inventory;

20 (q) Personal items such as cosmetics, smoking materials, newspapers  
21 and magazines, and clothing, except those used in patient activity  
22 programs;

23 (r) Fund-raising expenses, except those directly related to the  
24 patient activity program;

25 (s) Penalties and fines;

26 (t) Expenses related to telephones, radios, and similar appliances  
27 in patients' private accommodations;

28 (u) Televisions acquired prior to July 1, 2001;

29 (v) Federal, state, and other income taxes;

30 (w) Costs of special care services except where authorized by the  
31 department;

32 (x) Expenses of an employee benefit not in fact made available to  
33 all employees on an equal or fair basis, for example, key-man insurance  
34 and other insurance or retirement plans;

35 (y) Expenses of profit-sharing plans;

36 (z) Expenses related to the purchase and/or use of private or  
37 commercial airplanes which are in excess of what a prudent contractor  
38 would expend for the ordinary and economic provision of such a  
39 transportation need related to patient care;

1 (aa) Personal expenses and allowances of owners or relatives;  
2 (bb) All expenses of maintaining professional licenses or  
3 membership in professional organizations;  
4 (cc) Costs related to agreements not to compete;  
5 (dd) Amortization of goodwill, lease acquisition, or any other  
6 intangible asset, whether related to resident care or not, and whether  
7 recognized under generally accepted accounting principles or not;  
8 (ee) Expenses related to vehicles which are in excess of what a  
9 prudent contractor would expend for the ordinary and economic provision  
10 of transportation needs related to patient care;  
11 (ff) Legal and consultant fees in connection with a fair hearing  
12 against the department where a decision is rendered in favor of the  
13 department or where otherwise the determination of the department  
14 stands;  
15 (gg) Legal and consultant fees of a contractor or contractors in  
16 connection with a lawsuit against the department;  
17 (hh) Lease acquisition costs, goodwill, the cost of bed rights, or  
18 any other intangible assets;  
19 (ii) All rental or lease costs other than those provided in RCW  
20 74.46.300 on and after January 1, 1985;  
21 (jj) Postsurvey charges incurred by the facility as a result of  
22 subsequent inspections under RCW 18.51.050 which occur beyond the first  
23 postsurvey visit during the certification survey calendar year;  
24 (kk) Compensation paid for any purchased nursing care services,  
25 including registered nurse, licensed practical nurse, and nurse  
26 assistant services, obtained through service contract arrangement in  
27 excess of the amount of compensation paid for such hours of nursing  
28 care service had they been paid at the average hourly wage, including  
29 related taxes and benefits, for in-house nursing care staff of like  
30 classification at the same nursing facility, as reported in the most  
31 recent cost report period;  
32 (ll) For all partial or whole rate periods after July 17, 1984,  
33 costs of land and depreciable assets that cannot be reimbursed under  
34 the Deficit Reduction Act of 1984 and implementing state statutory and  
35 regulatory provisions;  
36 (mm) Costs reported by the contractor for a prior period to the  
37 extent such costs, due to statutory exemption, will not be incurred by  
38 the contractor in the period to be covered by the rate;



1 (nn) Costs of outside activities, for example, costs allocated to  
2 the use of a vehicle for personal purposes or related to the part of a  
3 facility leased out for office space;

4 (oo) Travel expenses outside the states of Idaho, Oregon, and  
5 Washington and the province of British Columbia. However, travel to or  
6 from the home or central office of a chain organization operating a  
7 nursing facility is allowed whether inside or outside these areas if  
8 the travel is necessary, ordinary, and related to resident care;

9 (pp) Moving expenses of employees in the absence of demonstrated,  
10 good-faith effort to recruit within the states of Idaho, Oregon, and  
11 Washington, and the province of British Columbia;

12 (qq) Depreciation in excess of four thousand dollars per year for  
13 each passenger car or other vehicle primarily used by the  
14 administrator, facility staff, or central office staff;

15 (rr) Costs for temporary health care personnel from a nursing pool  
16 not registered with the secretary of the department of health;

17 (ss) Payroll taxes associated with compensation in excess of  
18 allowable compensation of owners, relatives, and administrative  
19 personnel;

20 (tt) Costs and fees associated with filing a petition for  
21 bankruptcy;

22 (uu) All advertising or promotional costs, except reasonable costs  
23 of help wanted advertising;

24 (vv) Outside consultation expenses required to meet department-  
25 required minimum data set completion proficiency;

26 (ww) Interest charges assessed by any department or agency of this  
27 state for failure to make a timely refund of overpayments and interest  
28 expenses incurred for loans obtained to make the refunds;

29 (xx) All home office or central office costs, whether on or off the  
30 nursing facility premises, and whether allocated or not to specific  
31 services, in excess of the median of those adjusted costs for all  
32 facilities reporting such costs for the most recent report period;

33 ((and))

34 (yy) Tax expenses that a nursing facility has never incurred;

35 (zz) Depreciation expense in excess of eighty percent of a nursing  
36 facility's total depreciation expense on building and building  
37 improvements; and

38 (aaa) Depreciation expense on land improvements.

1       **Sec. 8.** RCW 74.46.431 and 2001 1st sp.s. c 8 s 5 are each amended  
2 to read as follows:

3       (1) Effective July 1, (~~(1999)~~) 2002, nursing facility medicaid  
4 payment rate allocations shall be facility-specific and shall have  
5 (~~(seven)~~) six components: Direct care, therapy care, support services,  
6 operations, property, and financing allowance(~~(, and variable return)~~).  
7 The department shall establish and adjust each of these components, as  
8 provided in this section and elsewhere in this chapter, for each  
9 medicaid nursing facility in this state.

10       (2) All component rate allocations for essential community  
11 providers as defined in this chapter shall be based upon a minimum  
12 facility occupancy of eighty-five percent of licensed beds, regardless  
13 of how many beds are set up or in use. For all facilities other than  
14 essential community providers, effective July 1, 2001, component rate  
15 allocations in direct care, therapy care, support services, variable  
16 return, operations, property, and financing allowance shall continue to  
17 be based upon a minimum facility occupancy of eighty-five percent of  
18 licensed beds. For all facilities other than essential community  
19 providers, effective July 1, 2002, (~~(the)~~) all component rate  
20 allocations (~~(in operations, property, and financing allowance)~~) shall  
21 be based upon a minimum facility occupancy of ninety percent of  
22 licensed beds, regardless of how many beds are set up or in use.

23       (3) Information and data sources used in determining medicaid  
24 payment rate allocations, including formulas, procedures, cost report  
25 periods, resident assessment instrument formats, resident assessment  
26 methodologies, and resident classification and case mix weighting  
27 methodologies, may be substituted or altered from time to time as  
28 determined by the department.

29       (4)(a) Direct care component rate allocations shall be established  
30 using adjusted cost report data covering at least six months. Adjusted  
31 cost report data from 1996 will be used for October 1, 1998, through  
32 June 30, 2001, direct care component rate allocations; adjusted cost  
33 report data from 1999 will be used for July 1, 2001, through June 30,  
34 2004, direct care component rate allocations.

35       (b) Direct care component rate allocations based on 1996 cost  
36 report data shall be adjusted annually for economic trends and  
37 conditions by a factor or factors defined in the biennial  
38 appropriations act. A different economic trends and conditions  
39 adjustment factor or factors may be defined in the biennial

1 appropriations act for facilities whose direct care component rate is  
2 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
3 74.46.506(5)(i).

4 (c) Direct care component rate allocations based on 1999 cost  
5 report data shall be adjusted annually for economic trends and  
6 conditions by a factor or factors defined in the biennial  
7 appropriations act. A different economic trends and conditions  
8 adjustment factor or factors may be defined in the biennial  
9 appropriations act for facilities whose direct care component rate is  
10 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
11 74.46.506(5)(i).

12 (5)(a) Therapy care component rate allocations shall be established  
13 using adjusted cost report data covering at least six months. Adjusted  
14 cost report data from 1996 will be used for October 1, 1998, through  
15 June 30, 2001, therapy care component rate allocations; adjusted cost  
16 report data from 1999 will be used for July 1, 2001, through June 30,  
17 2004, therapy care component rate allocations.

18 (b) Therapy care component rate allocations shall be adjusted  
19 annually for economic trends and conditions by a factor or factors  
20 defined in the biennial appropriations act.

21 (6)(a) Support services component rate allocations shall be  
22 established using adjusted cost report data covering at least six  
23 months. Adjusted cost report data from 1996 shall be used for October  
24 1, 1998, through June 30, 2001, support services component rate  
25 allocations; adjusted cost report data from 1999 shall be used for July  
26 1, 2001, through June 30, 2004, support services component rate  
27 allocations.

28 (b) Support services component rate allocations shall be adjusted  
29 annually for economic trends and conditions by a factor or factors  
30 defined in the biennial appropriations act.

31 (7)(a) Operations component rate allocations shall be established  
32 using adjusted cost report data covering at least six months. Adjusted  
33 cost report data from 1996 shall be used for October 1, 1998, through  
34 June 30, 2001, operations component rate allocations; adjusted cost  
35 report data from 1999 shall be used for July 1, 2001, through June 30,  
36 2004, operations component rate allocations.

37 (b) Operations component rate allocations shall be adjusted  
38 annually for economic trends and conditions by a factor or factors  
39 defined in the biennial appropriations act.

1 (8) For July 1, 1998, through September 30, 1998, a facility's  
2 property and return on investment component rates shall be the  
3 facility's June 30, 1998, property and return on investment component  
4 rates, without increase. For October 1, 1998, through June 30, 1999,  
5 a facility's property and return on investment component rates shall be  
6 rebased utilizing 1997 adjusted cost report data covering at least six  
7 months of data.

8 (9) Total payment rates under the nursing facility medicaid payment  
9 system shall not exceed facility rates charged to the general public  
10 for comparable services.

11 (10) Medicaid contractors shall pay to all facility staff a minimum  
12 wage of the greater of the state minimum wage or the federal minimum  
13 wage.

14 (11) The department shall establish in rule procedures, principles,  
15 and conditions for determining component rate allocations for  
16 facilities in circumstances not directly addressed by this chapter,  
17 including but not limited to: The need to prorate inflation for  
18 partial-period cost report data, newly constructed facilities, existing  
19 facilities entering the medicaid program for the first time or after a  
20 period of absence from the program, existing facilities with expanded  
21 new bed capacity, existing medicaid facilities following a change of  
22 ownership of the nursing facility business, facilities banking beds or  
23 converting beds back into service, facilities temporarily reducing the  
24 number of set-up beds during a remodel, facilities having less than six  
25 months of either resident assessment, cost report data, or both, under  
26 the current contractor prior to rate setting, and other circumstances.

27 (12) The department shall establish in rule procedures, principles,  
28 and conditions, including necessary threshold costs, for adjusting  
29 rates to reflect capital improvements or new requirements imposed by  
30 the department or the federal government. Any such rate adjustments  
31 are subject to the provisions of RCW 74.46.421.

32 (13) Effective July 1, 2001, medicaid rates shall continue to be  
33 revised downward in all components, in accordance with department  
34 rules, for facilities converting banked beds to active service under  
35 chapter 70.38 RCW, by using the facility's increased licensed bed  
36 capacity to recalculate minimum occupancy for rate setting. However,  
37 for facilities other than essential community providers which bank beds  
38 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be  
39 revised upward, in accordance with department rules, in direct care,

1 therapy care, and support services(~~(, and variable return)~~) components  
2 only, by using the facility's decreased licensed bed capacity to  
3 recalculate minimum occupancy for rate setting, but no upward revision  
4 shall be made to operations, property, or financing allowance component  
5 rates.

6 (14) Facilities obtaining a certificate of need or a certificate of  
7 need exemption under chapter 70.38 RCW after June 30, 2001, must have  
8 a certificate of capital authorization in order for (a) the  
9 depreciation resulting from the capitalized addition to be included in  
10 calculation of the facility's property component rate allocation; and  
11 (b) the net invested funds associated with the capitalized addition to  
12 be included in calculation of the facility's financing allowance rate  
13 allocation.

14 **Sec. 9.** RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended  
15 to read as follows:

16 (1) Effective July 1, 2001, the property component rate allocation  
17 for each facility shall be determined by dividing the sum of the  
18 reported allowable prior period actual depreciation, subject to RCW  
19 74.46.310 through 74.46.380, adjusted for any capitalized additions or  
20 replacements approved by the department, and the retained savings from  
21 such cost center, by the greater of a facility's total resident days  
22 for the facility in the prior period or resident days as calculated on  
23 eighty-five percent facility occupancy. Effective July 1, 2002, the  
24 property component rate allocation for all facilities, except essential  
25 community providers, shall be set by using the greater of a facility's  
26 total resident days from the most recent cost report period or resident  
27 days calculated at ninety percent facility occupancy. If a capitalized  
28 addition or retirement of an asset will result in a different licensed  
29 bed capacity during the ensuing period, the prior period total resident  
30 days used in computing the property component rate shall be adjusted to  
31 anticipated resident day level.

32 (2) A nursing facility's property component rate allocation shall  
33 be rebased annually, effective July 1st, in accordance with this  
34 section and this chapter.

35 (3) When a certificate of need for a new facility is requested, the  
36 department, in reaching its decision, shall take into consideration  
37 per-bed land and building construction costs for the facility which  
38 shall not exceed a maximum to be established by the secretary.

1 (4) Effective July 1, 2001, for the purpose of calculating a  
2 nursing facility's property component rate, if a contractor has elected  
3 to bank licensed beds (~~(prior to April 1)~~) before May 25, 2001, or  
4 elects to convert banked beds to active service at any time, under  
5 chapter 70.38 RCW, the department shall use the facility's new licensed  
6 bed capacity to recalculate minimum occupancy for rate setting and  
7 revise the property component rate, as needed, effective as of the date  
8 the beds are banked or converted to active service. However, in no  
9 case shall the department use less than eighty-five percent occupancy  
10 of the facility's licensed bed capacity after banking or conversion.  
11 Effective July 1, 2002, in no case, other than essential community  
12 providers, shall the department use less than ninety percent occupancy  
13 of the facility's licensed bed capacity after conversion.

14 (5) The property component rate allocations calculated in  
15 accordance with this section shall be adjusted to the extent necessary  
16 to comply with RCW 74.46.421.

17 **Sec. 10.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended  
18 to read as follows:

19 (1) Beginning July 1, 1999, the department shall establish for each  
20 medicaid nursing facility a financing allowance component rate  
21 allocation. The financing allowance component rate shall be rebased  
22 annually, effective July 1st, in accordance with the provisions of this  
23 section and this chapter.

24 (2) Effective July 1, (~~(2001)~~) 2002, the financing allowance shall  
25 be determined by multiplying the net invested funds of each facility by  
26 (~~(.10)~~) .06, and dividing by the greater of a nursing facility's total  
27 resident days from the most recent cost report period or resident days  
28 calculated on (~~(eighty-five)~~) ninety percent facility occupancy.  
29 (~~Effective July 1, 2002, the financing allowance component rate~~  
30 ~~allocation for all facilities, other than essential community~~  
31 ~~providers, shall be set by using the greater of a facility's total~~  
32 ~~resident days from the most recent cost report period or resident days~~  
33 ~~calculated at ninety percent facility occupancy. However, assets~~  
34 ~~acquired on or after May 17, 1999, shall be grouped in a separate~~  
35 ~~financing allowance calculation that shall be multiplied by .085. The~~  
36 ~~financing allowance factor of .085 shall not be applied to the net~~  
37 ~~invested funds pertaining to new construction or major renovations~~  
38 ~~receiving certificate of need approval or an exemption from certificate~~

1 of need requirements under chapter 70.38 RCW, or to working drawings  
2 that have been submitted to the department of health for construction  
3 review approval, prior to May 17, 1999.) However, essential community  
4 providers will have their resident days calculated on eighty-five  
5 percent facility occupancy. If a capitalized addition, renovation,  
6 replacement, or retirement of an asset will result in a different  
7 licensed bed capacity ((during the ensuing period, the prior period)),  
8 the financing allowance component rate allocation for all facilities,  
9 other than essential community providers will be set by using the  
10 greater of total resident days from the most recent cost report period  
11 used in computing the financing allowance ((shall be adjusted to the  
12 greater of the anticipated resident day level)) or eighty-five percent  
13 of the new licensed bed capacity. Effective July 1, 2002, for all  
14 facilities, other than essential community providers, the total  
15 resident days used to compute the financing allowance after a  
16 capitalized addition, renovation, replacement, or retirement of an  
17 asset shall be set by using the greater of a facility's total resident  
18 days from the most recent cost report period or resident days  
19 calculated at ninety percent facility occupancy.

20 (3) In computing the portion of net invested funds representing the  
21 net book value of tangible fixed assets, the same assets, depreciation  
22 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,  
23 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,  
24 shall be utilized((, except that the capitalized cost of land upon  
25 which the facility is located and such other contiguous land which is  
26 reasonable and necessary for use in the regular course of providing  
27 resident care shall also be included. Subject to provisions and  
28 limitations contained in this chapter, for land purchased by owners or  
29 lessors before July 18, 1984, capitalized cost of land shall be the  
30 buyer's capitalized cost. For all partial or whole rate periods after  
31 July 17, 1984, if the land is purchased after July 17, 1984,  
32 capitalized cost shall be that of the owner of record on July 17, 1984,  
33 or buyer's capitalized cost, whichever is lower)). In the case of  
34 leased facilities where the net invested funds are unknown or the  
35 contractor is unable to provide necessary information to determine net  
36 invested funds, the secretary shall have the authority to determine an  
37 amount for net invested funds based on an appraisal conducted according  
38 to RCW 74.46.360(1).

1 (4) Effective July 1, 2001, for the purpose of calculating a  
2 nursing facility's financing allowance component rate, if a contractor  
3 has elected to bank licensed beds prior to May 25, 2001, or elects to  
4 convert banked beds to active service at any time, under chapter 70.38  
5 RCW, the department shall use the facility's new licensed bed capacity  
6 to recalculate minimum occupancy for rate setting and revise the  
7 financing allowance component rate, as needed, effective as of the date  
8 the beds are banked or converted to active service. However, in no  
9 case shall the department use less than eighty-five percent occupancy  
10 of the facility's licensed bed capacity after banking or conversion.  
11 Effective July 1, 2002, in no case, other than for essential community  
12 providers, shall the department use less than ninety percent occupancy  
13 of the facility's licensed bed capacity after conversion.

14 (5) The financing allowance rate allocation calculated in  
15 accordance with this section shall be adjusted to the extent necessary  
16 to comply with RCW 74.46.421.

17 **Sec. 11.** RCW 74.46.439 and 1999 c 353 s 12 are each amended to  
18 read as follows:

19 (1) In the case of a facility that was leased by the contractor as  
20 of January 1, 1980, in an arm's-length agreement, which continues to be  
21 leased under the same lease agreement, and for which the annualized  
22 lease payment, plus any interest and depreciation expenses associated  
23 with contractor-owned assets, for the period covered by the prospective  
24 rates, divided by the contractor's total resident days, minus the  
25 property component rate allocation, is more than the sum of the  
26 financing allowance (~~and the variable return rate~~) determined  
27 according to this chapter, the following shall apply:

28 (a) The financing allowance shall be recomputed substituting the  
29 fair market value of the assets as of January 1, 1982, as determined by  
30 the department of general administration through an appraisal  
31 procedure, less accumulated depreciation on the lessor's assets since  
32 January 1, 1982, for the net book value of the assets in determining  
33 net invested funds for the facility. A determination by the department  
34 of general administration of fair market value shall be final unless  
35 the procedure used to make such a determination is shown to be  
36 arbitrary and capricious.

37 (b) The (~~sum of the~~) financing allowance component rate computed  
38 under (a) of this subsection (~~and the variable return rate~~) shall be



1 compared to the annualized lease payment, plus any interest and  
2 depreciation associated with contractor-owned assets, for the period  
3 covered by the prospective rates, divided by the contractor's total  
4 resident days, minus the property component rate. The lesser of the  
5 two amounts shall be called the alternate (~~return on investment~~)  
6 financing allowance rate.

7 (c) The (~~sum of the~~) financing allowance (~~and variable return~~)  
8 rate determined according to this chapter or the alternate (~~return on~~  
9 ~~investment~~) financing allowance component rate, whichever is greater,  
10 shall be added to the prospective rates of the contractor.

11 (2) In the case of a facility that was leased by the contractor as  
12 of January 1, 1980, in an arm's-length agreement, if the lease is  
13 renewed or extended under a provision of the lease, the treatment  
14 provided in subsection (1) of this section shall be applied, except  
15 that in the case of renewals or extensions made subsequent to April 1,  
16 1985, reimbursement for the annualized lease payment shall be no  
17 greater than the reimbursement for the annualized lease payment for the  
18 last year prior to the renewal or extension of the lease.

19 (3) The alternate (~~return on investment~~) financing allowance  
20 component rate allocations calculated in accordance with this section  
21 shall be adjusted to the extent necessary to comply with RCW 74.46.421.

22 **Sec. 12.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each  
23 amended to read as follows:

24 (1) The direct care component rate allocation corresponds to the  
25 provision of nursing care for one resident of a nursing facility for  
26 one day, including direct care supplies. Therapy services and  
27 supplies, which correspond to the therapy care component rate, shall be  
28 excluded. The direct care component rate includes elements of case mix  
29 determined consistent with the principles of this section and other  
30 applicable provisions of this chapter.

31 (2) Beginning October 1, 1998, the department shall determine and  
32 update quarterly for each nursing facility serving medicaid residents  
33 a facility-specific per-resident day direct care component rate  
34 allocation, to be effective on the first day of each calendar quarter.  
35 In determining direct care component rates the department shall  
36 utilize, as specified in this section, minimum data set resident  
37 assessment data for each resident of the facility, as transmitted to,  
38 and if necessary corrected by, the department in the resident

1 assessment instrument format approved by federal authorities for use in  
2 this state.

3 (3) The department may question the accuracy of assessment data for  
4 any resident and utilize corrected or substitute information, however  
5 derived, in determining direct care component rates. The department is  
6 authorized to impose civil fines and to take adverse rate actions  
7 against a contractor, as specified by the department in rule, in order  
8 to obtain compliance with resident assessment and data transmission  
9 requirements and to ensure accuracy.

10 (4) Cost report data used in setting direct care component rate  
11 allocations shall be 1996 and 1999, for rate periods as specified in  
12 RCW 74.46.431(4)(a).

13 (5) Beginning October 1, 1998, the department shall rebase each  
14 nursing facility's direct care component rate allocation as described  
15 in RCW 74.46.431, adjust its direct care component rate allocation for  
16 economic trends and conditions as described in RCW 74.46.431, and  
17 update its medicaid average case mix index, consistent with the  
18 following:

19 (a) Reduce total direct care costs reported by each nursing  
20 facility for the applicable cost report period specified in RCW  
21 74.46.431(4)(a) to reflect any department adjustments(~~(, and to~~  
22 ~~eliminate reported resident therapy costs and adjustments,)~~) in order  
23 to derive the facility's total allowable direct care cost;

24 (b) Divide each facility's total allowable direct care cost by the  
25 greater of its adjusted resident days for the same report period(~~(,~~  
26 ~~increased if necessary to a minimum occupancy of eighty five percent;~~  
27 ~~that is, the greater of actual)~~) or imputed occupancy at:

28 (i) Eighty-five percent of licensed beds, to derive the facility's  
29 allowable direct care cost per resident day; or

30 (ii) Effective July 1, 2002, ninety percent except, essential  
31 community providers will have their imputed occupancy set using eighty-  
32 five percent of licensed beds, to derive the facility's allowable  
33 direct care cost per resident day;

34 (c) Adjust the facility's per resident day direct care cost by the  
35 applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive  
36 its adjusted allowable direct care cost per resident day;

37 (d) Divide each facility's adjusted allowable direct care cost per  
38 resident day by the facility average case mix index for the applicable

1 quarters specified by RCW 74.46.501(7)(b) to derive the facility's  
2 allowable direct care cost per case mix unit;

3 (e) Effective for July 1, 2001, rate setting, divide nursing  
4 facilities into at least two and, if applicable, three peer groups:  
5 Those located in nonurban counties; those located in high labor-cost  
6 counties, if any; and those located in other urban counties;

7 (f) Array separately the allowable direct care cost per case mix  
8 unit for all facilities in nonurban counties; for all facilities in  
9 high labor-cost counties, if applicable; and for all facilities in  
10 other urban counties, and determine the median allowable direct care  
11 cost per case mix unit for each peer group;

12 (g) Except as provided in (i) of this subsection, from October 1,  
13 1998, through June 30, 2000, determine each facility's quarterly direct  
14 care component rate as follows:

15 (i) Any facility whose allowable cost per case mix unit is less  
16 than eighty-five percent of the facility's peer group median  
17 established under (f) of this subsection shall be assigned a cost per  
18 case mix unit equal to eighty-five percent of the facility's peer group  
19 median, and shall have a direct care component rate allocation equal to  
20 the facility's assigned cost per case mix unit multiplied by that  
21 facility's medicaid average case mix index from the applicable quarter  
22 specified in RCW 74.46.501(7)(c);

23 (ii) Any facility whose allowable cost per case mix unit is greater  
24 than one hundred fifteen percent of the peer group median established  
25 under (f) of this subsection shall be assigned a cost per case mix unit  
26 equal to one hundred fifteen percent of the peer group median, and  
27 shall have a direct care component rate allocation equal to the  
28 facility's assigned cost per case mix unit multiplied by that  
29 facility's medicaid average case mix index from the applicable quarter  
30 specified in RCW 74.46.501(7)(c);

31 (iii) Any facility whose allowable cost per case mix unit is  
32 between eighty-five and one hundred fifteen percent of the peer group  
33 median established under (f) of this subsection shall have a direct  
34 care component rate allocation equal to the facility's allowable cost  
35 per case mix unit multiplied by that facility's medicaid average case  
36 mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

37 (h) Except as provided in (i) of this subsection, from July 1,  
38 2000, forward, and for all future rate setting, determine each  
39 facility's quarterly direct care component rate as follows:

1 (i) Any facility whose allowable cost per case mix unit is less  
2 than ninety percent of the facility's peer group median established  
3 under (f) of this subsection shall be assigned a cost per case mix unit  
4 equal to ninety percent of the facility's peer group median, and shall  
5 have a direct care component rate allocation equal to the facility's  
6 assigned cost per case mix unit multiplied by that facility's medicaid  
7 average case mix index from the applicable quarter specified in RCW  
8 74.46.501(7)(c);

9 (ii) Any facility whose allowable cost per case mix unit is greater  
10 than one hundred ten percent of the peer group median established under  
11 (f) of this subsection shall be assigned a cost per case mix unit equal  
12 to one hundred ten percent of the peer group median, and shall have a  
13 direct care component rate allocation equal to the facility's assigned  
14 cost per case mix unit multiplied by that facility's medicaid average  
15 case mix index from the applicable quarter specified in RCW  
16 74.46.501(7)(c);

17 (iii) Any facility whose allowable cost per case mix unit is  
18 between ninety and one hundred ten percent of the peer group median  
19 established under (f) of this subsection shall have a direct care  
20 component rate allocation equal to the facility's allowable cost per  
21 case mix unit multiplied by that facility's medicaid average case mix  
22 index from the applicable quarter specified in RCW 74.46.501(7)(c);

23 (i)(i) Between October 1, 1998, and June 30, 2000, the department  
24 shall compare each facility's direct care component rate allocation  
25 calculated under (g) of this subsection with the facility's nursing  
26 services component rate in effect on September 30, 1998, less therapy  
27 costs, plus any exceptional care offsets as reported on the cost  
28 report, adjusted for economic trends and conditions as provided in RCW  
29 74.46.431. A facility shall receive the higher of the two rates.

30 (ii) Between July 1, 2000, and June 30, 2002, the department shall  
31 compare each facility's direct care component rate allocation  
32 calculated under (h) of this subsection with the facility's direct care  
33 component rate in effect on June 30, 2000. A facility shall receive  
34 the higher of the two rates. Between July 1, 2001, and June 30, 2002,  
35 if during any quarter a facility whose rate paid under (h) of this  
36 subsection is greater than either the direct care rate in effect on  
37 June 30, 2000, or than that facility's allowable direct care cost per  
38 case mix unit calculated in (d) of this subsection multiplied by that  
39 facility's medicaid average case mix index from the applicable quarter

1 specified in RCW 74.46.501(7)(c), the facility shall be paid in that  
2 and each subsequent quarter pursuant to (h) of this subsection and  
3 shall not be entitled to the greater of the two rates.

4 (iii) Effective July 1, 2002, all direct care component rate  
5 allocations shall be as determined under (h) of this subsection.

6 (6) The direct care component rate allocations calculated in  
7 accordance with this section shall be adjusted to the extent necessary  
8 to comply with RCW 74.46.421.

9 (7) Payments resulting from increases in direct care component  
10 rates, granted under authority of RCW 74.46.508(1) for a facility's  
11 exceptional care residents, shall be offset against the facility's  
12 examined, allowable direct care costs, for each report year or partial  
13 period such increases are paid. Such reductions in allowable direct  
14 care costs shall be for rate setting, settlement, and other purposes  
15 deemed appropriate by the department.

16 **Sec. 13.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each  
17 amended to read as follows:

18 (1) The therapy care component rate allocation corresponds to the  
19 provision of medicaid one-on-one therapy provided by a qualified  
20 therapist as defined in this chapter, including therapy supplies and  
21 therapy consultation, for one day for one medicaid resident of a  
22 nursing facility. The therapy care component rate allocation for  
23 October 1, 1998, through June 30, 2001, shall be based on adjusted  
24 therapy costs and days from calendar year 1996. The therapy component  
25 rate allocation for July 1, 2001, through June 30, 2004, shall be based  
26 on adjusted therapy costs and days from calendar year 1999. The  
27 therapy care component rate shall be adjusted for economic trends and  
28 conditions as specified in RCW 74.46.431(5)(b), and shall be determined  
29 in accordance with this section.

30 (2) In rebasing, as provided in RCW 74.46.431(5)(a), the department  
31 shall take from the cost reports of facilities the following reported  
32 information:

33 (a) Direct one-on-one therapy charges for all residents by payer  
34 including charges for supplies;

35 (b) The total units or modules of therapy care for all residents by  
36 type of therapy provided, for example, speech or physical. A unit or  
37 module of therapy care is considered to be fifteen minutes of one-on-  
38 one therapy provided by a qualified therapist or support personnel; and

1 (c) Therapy consulting expenses for all residents.

2 (3) The department shall determine for all residents the total cost  
3 per unit of therapy for each type of therapy by dividing the total  
4 adjusted one-on-one therapy expense for each type by the total units  
5 provided for that therapy type.

6 (4) The department shall divide medicaid nursing facilities in this  
7 state into two peer groups:

8 (a) Those facilities located within urban counties; and

9 (b) Those located within nonurban counties.

10 The department shall array the facilities in each peer group from  
11 highest to lowest based on their total cost per unit of therapy for  
12 each therapy type. The department shall determine the median total  
13 cost per unit of therapy for each therapy type and add ten percent of  
14 median total cost per unit of therapy. The cost per unit of therapy  
15 for each therapy type at a nursing facility shall be the lesser of its  
16 cost per unit of therapy for each therapy type or the median total cost  
17 per unit plus ten percent for each therapy type for its peer group.

18 (5) The department shall calculate each nursing facility's therapy  
19 care component rate allocation as follows:

20 (a) To determine the allowable total therapy cost for each therapy  
21 type, the allowable cost per unit of therapy for each type of therapy  
22 shall be multiplied by the total therapy units for each type of  
23 therapy;

24 (b) The medicaid allowable one-on-one therapy expense shall be  
25 calculated taking the allowable total therapy cost for each therapy  
26 type times the medicaid percent of total therapy charges for each  
27 therapy type;

28 (c) The medicaid allowable one-on-one therapy expense for each  
29 therapy type shall be divided by total adjusted medicaid days to arrive  
30 at the medicaid one-on-one therapy cost per patient day for each  
31 therapy type;

32 (d) The medicaid one-on-one therapy cost per patient day for each  
33 therapy type shall be multiplied by total adjusted patient days for all  
34 residents to calculate the total allowable one-on-one therapy expense.  
35 The lesser of the total allowable therapy consultant expense for the  
36 therapy type or a reasonable percentage of allowable therapy consultant  
37 expense for each therapy type, as established in rule by the  
38 department, shall be added to the total allowable one-on-one therapy  
39 expense to determine the allowable therapy cost for each therapy type;

1 (e) The allowable therapy cost for each therapy type shall be added  
2 together, the sum of which shall be the total allowable therapy expense  
3 for the nursing facility;

4 (f) Effective July 1, 2002, the total allowable therapy expense  
5 will be divided by the greater of adjusted total patient days from the  
6 cost report on which the therapy expenses were reported((7)) or patient  
7 days at ((eighty-five)) ninety percent occupancy of licensed beds.  
8 However, essential community providers will have their imputed  
9 occupancy set using eighty-five percent. The outcome shall be the  
10 nursing facility's therapy care component rate allocation.

11 (6) The therapy care component rate allocations calculated in  
12 accordance with this section shall be adjusted to the extent necessary  
13 to comply with RCW 74.46.421.

14 (7) The therapy care component rate shall be suspended for medicaid  
15 residents in qualified nursing facilities designated by the department  
16 who are receiving therapy paid by the department outside the facility  
17 daily rate under RCW 74.46.508(2).

18 (8) The department will adopt rules to equalize rates between  
19 nursing facilities based on the ratio of medicaid residents receiving  
20 therapy care to private residents receiving therapy care.

21 **Sec. 14.** RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each  
22 amended to read as follows:

23 (1) The support services component rate allocation corresponds to  
24 the provision of food, food preparation, dietary, housekeeping, and  
25 laundry services for one resident for one day.

26 (2) Beginning October 1, 1998, the department shall determine each  
27 medicaid nursing facility's support services component rate allocation  
28 using cost report data specified by RCW 74.46.431(6).

29 (3) To determine each facility's support services component rate  
30 allocation, the department shall, effective July 1, 2002:

31 (a) Divide each facility's total allowable support services costs  
32 by the greater of its adjusted resident days for the applicable cost  
33 report period or imputed occupancy at ninety percent. However,  
34 essential community providers will have their imputed occupancy set  
35 using eighty-five percent of licensed beds to derive the facility's  
36 allowable support services costs per resident day;

37 (b) Array facilities' adjusted support services costs per adjusted  
38 resident day for each facility from facilities' cost reports from the

1 applicable report year, for facilities located within urban counties,  
2 and for those located within nonurban counties and determine the median  
3 adjusted cost for each peer group;

4 ~~((b))~~ (c) Set each facility's support services component rate at  
5 the lower of the facility's per resident day adjusted support services  
6 costs from the applicable cost report period or eighty-eight percent of  
7 the adjusted median per resident day support services cost for that  
8 facility's peer group, either urban counties or nonurban counties(~~(7~~  
9 ~~plus ten percent))~~); and

10 ~~((e))~~ (d) Adjust each facility's support services component rate  
11 for economic trends and conditions as provided in RCW 74.46.431(6).

12 (4) The support services component rate allocations calculated in  
13 accordance with this section shall be adjusted to the extent necessary  
14 to comply with RCW 74.46.421.

15 **Sec. 15.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each  
16 amended to read as follows:

17 (1) The operations component rate allocation corresponds to the  
18 general operation of a nursing facility for one resident for one day,  
19 including but not limited to management, administration, utilities,  
20 office supplies, accounting and bookkeeping, minor building  
21 maintenance, minor equipment repairs and replacements, and other  
22 supplies and services, exclusive of direct care, therapy care, support  
23 services, property, and financing allowance(~~(7 and variable return)~~).

24 (2) Beginning October 1, 1998, the department shall determine each  
25 medicaid nursing facility's operations component rate allocation using  
26 cost report data specified by RCW 74.46.431(7)(a). Effective July 1,  
27 2002, operations component rates for all facilities except essential  
28 community providers shall be based upon a minimum occupancy of ninety  
29 percent of licensed beds, and no operations component rate shall be  
30 revised in response to beds banked on or after May 25, 2001, under  
31 chapter 70.38 RCW.

32 (3) To determine each facility's operations component rate the  
33 department shall:

34 (a) Array facilities' adjusted general operations costs per  
35 adjusted resident day for each facility from facilities' cost reports  
36 from the applicable report year, for facilities located within urban  
37 counties and for those located within nonurban counties and determine  
38 the median adjusted cost for each peer group;



1 (b) Set each facility's operations component rate at the lower of:

2 (i) The facility's per resident day adjusted operations costs from  
3 the applicable cost report period adjusted if necessary to a minimum  
4 occupancy of eighty-five percent of licensed beds before July 1, 2002,  
5 and ninety percent effective July 1, 2002; or

6 (ii) Eighty percent of the adjusted median per resident day general  
7 operations cost for that facility's peer group, urban counties or  
8 nonurban counties; and

9 (c) Adjust each facility's operations component rate for economic  
10 trends and conditions as provided in RCW 74.46.431(7)(b).

11 (4) The operations component rate allocations calculated in  
12 accordance with this section shall be adjusted to the extent necessary  
13 to comply with RCW 74.46.421.

14 NEW SECTION. **Sec. 16.** RCW 74.46.433 (Variable return component  
15 rate allocation) and 2001 1st sp.s. c 8 s 6 & 1999 c 353 s 9 are each  
16 repealed.

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