

CERTIFICATION OF ENROLLMENT  
**ENGROSSED SUBSTITUTE SENATE BILL 6158**

60th Legislature  
2007 Regular Session

Passed by the Senate April 20, 2007  
YEAS 48 NAYS 1

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**President of the Senate**

Passed by the House April 21, 2007  
YEAS 94 NAYS 3

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**Speaker of the House of Representatives**

Approved

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**Governor of the State of Washington**

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6158** as passed by the Senate and the House of Representatives on the dates hereon set forth.

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**Secretary**

FILED

**Secretary of State  
State of Washington**

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**ENGROSSED SUBSTITUTE SENATE BILL 6158**

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Passed Legislature - 2007 Regular Session

**State of Washington                      60th Legislature                      2007 Regular Session**

**By** Senate Committee on Ways & Means (originally sponsored by Senator Prentice)

READ FIRST TIME 04/19/07.

1            AN ACT Relating to biennial rebasing of nursing facility medicaid  
2 payment rates; amending RCW 74.46.410, 74.46.431, 74.46.506, 74.46.511,  
3 74.46.521, and 74.46.020; adding a new section to chapter 74.46 RCW;  
4 providing an effective date; and declaring an emergency.

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

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

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

11            (2) Unallowable costs include, but are not limited to, the  
12 following:

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

17            (b) Costs of services and items provided to recipients which are  
18 covered by the department's medical care program but not included in

1 the medicaid per-resident day payment rate established by the  
2 department under this chapter;

3 (c) Costs associated with a capital expenditure subject to section  
4 1122 approval (part 100, Title 42 C.F.R.) if the department found it  
5 was not consistent with applicable standards, criteria, or plans. If  
6 the department was not given timely notice of a proposed capital  
7 expenditure, all associated costs will be unallowable up to the date  
8 they are determined to be reimbursable under applicable federal  
9 regulations;

10 (d) Costs associated with a construction or acquisition project  
11 requiring certificate of need approval, or exemption from the  
12 requirements for certificate of need for the replacement of existing  
13 nursing home beds, pursuant to chapter 70.38 RCW if such approval or  
14 exemption was not obtained;

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

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

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

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

27 (i) Costs applicable to services, facilities, and supplies  
28 furnished by a related organization in excess of the lower of the cost  
29 to the related organization or the price of comparable services,  
30 facilities, or supplies purchased elsewhere;

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

38 (k) Charity and courtesy allowances;

- 1 (l) Cash, assessments, or other contributions, excluding dues, to  
2 charitable organizations, professional organizations, trade  
3 associations, or political parties, and costs incurred to improve  
4 community or public relations;
- 5 (m) Vending machine expenses;
- 6 (n) Expenses for barber or beautician services not included in  
7 routine care;
- 8 (o) Funeral and burial expenses;
- 9 (p) Costs of gift shop operations and inventory;
- 10 (q) Personal items such as cosmetics, smoking materials, newspapers  
11 and magazines, and clothing, except those used in patient activity  
12 programs;
- 13 (r) Fund-raising expenses, except those directly related to the  
14 patient activity program;
- 15 (s) Penalties and fines;
- 16 (t) Expenses related to telephones, radios, and similar appliances  
17 in patients' private accommodations;
- 18 (u) Televisions acquired prior to July 1, 2001;
- 19 (v) Federal, state, and other income taxes;
- 20 (w) Costs of special care services except where authorized by the  
21 department;
- 22 (x) Expenses of an employee benefit not in fact made available to  
23 all employees on an equal or fair basis, for example, key-man insurance  
24 and other insurance or retirement plans;
- 25 (y) Expenses of profit-sharing plans;
- 26 (z) Expenses related to the purchase and/or use of private or  
27 commercial airplanes which are in excess of what a prudent contractor  
28 would expend for the ordinary and economic provision of such a  
29 transportation need related to patient care;
- 30 (aa) Personal expenses and allowances of owners or relatives;
- 31 (bb) All expenses of maintaining professional licenses or  
32 membership in professional organizations;
- 33 (cc) Costs related to agreements not to compete;
- 34 (dd) Amortization of goodwill, lease acquisition, or any other  
35 intangible asset, whether related to resident care or not, and whether  
36 recognized under generally accepted accounting principles or not;
- 37 (ee) Expenses related to vehicles which are in excess of what a

1 prudent contractor would expend for the ordinary and economic provision  
2 of transportation needs related to patient care;

3 (ff) Legal and consultant fees in connection with a fair hearing  
4 against the department where a decision is rendered in favor of the  
5 department or where otherwise the determination of the department  
6 stands;

7 (gg) Legal and consultant fees of a contractor or contractors in  
8 connection with a lawsuit against the department;

9 (hh) Lease acquisition costs, goodwill, the cost of bed rights, or  
10 any other intangible assets;

11 (ii) All rental or lease costs other than those provided in RCW  
12 74.46.300 on and after January 1, 1985;

13 (jj) Postsurvey charges incurred by the facility as a result of  
14 subsequent inspections under RCW 18.51.050 which occur beyond the first  
15 postsurvey visit during the certification survey calendar year;

16 (kk) Compensation paid for any purchased nursing care services,  
17 including registered nurse, licensed practical nurse, and nurse  
18 assistant services, obtained through service contract arrangement in  
19 excess of the amount of compensation paid for such hours of nursing  
20 care service had they been paid at the average hourly wage, including  
21 related taxes and benefits, for in-house nursing care staff of like  
22 classification at the same nursing facility, as reported in the most  
23 recent cost report period;

24 (ll) For all partial or whole rate periods after July 17, 1984,  
25 costs of land and depreciable assets that cannot be reimbursed under  
26 the Deficit Reduction Act of 1984 and implementing state statutory and  
27 regulatory provisions;

28 (mm) Costs reported by the contractor for a prior period to the  
29 extent such costs, due to statutory exemption, will not be incurred by  
30 the contractor in the period to be covered by the rate;

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

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

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

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

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

9 (ss) Payroll taxes associated with compensation in excess of  
10 allowable compensation of owners, relatives, and administrative  
11 personnel;

12 (tt) Costs and fees associated with filing a petition for  
13 bankruptcy;

14 (uu) All advertising or promotional costs, except reasonable costs  
15 of help wanted advertising;

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

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

21 (xx) All home office or central office costs, whether on or off the  
22 nursing facility premises, and whether allocated or not to specific  
23 services, in excess of the median of those adjusted costs for all  
24 facilities reporting such costs for the most recent report period;  
25 (~~and~~)

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

27 (zz) Effective July 1, 2007, and for all future rate settings, any  
28 costs associated with the quality maintenance fee repealed by chapter  
29 241, Laws of 2006.

30 **Sec. 2.** RCW 74.46.431 and 2006 c 258 s 2 are each amended to read  
31 as follows:

32 (1) Effective July 1, 1999, nursing facility medicaid payment rate  
33 allocations shall be facility-specific and shall have seven components:  
34 Direct care, therapy care, support services, operations, property,  
35 financing allowance, and variable return. The department shall  
36 establish and adjust each of these components, as provided in this

1 section and elsewhere in this chapter, for each medicaid nursing  
2 facility in this state.

3 (2) Component rate allocations in therapy care, support services,  
4 variable return, operations, property, and financing allowance for  
5 essential community providers as defined in this chapter shall be based  
6 upon a minimum facility occupancy of eighty-five percent of licensed  
7 beds, regardless of how many beds are set up or in use. For all  
8 facilities other than essential community providers, effective July 1,  
9 2001, component rate allocations in direct care, therapy care, support  
10 services, variable return, operations, property, and financing  
11 allowance shall continue to be based upon a minimum facility occupancy  
12 of eighty-five percent of licensed beds. For all facilities other than  
13 essential community providers, effective July 1, 2002, the component  
14 rate allocations in operations, property, and financing allowance shall  
15 be based upon a minimum facility occupancy of ninety percent of  
16 licensed beds, regardless of how many beds are set up or in use. For  
17 all facilities, effective July 1, 2006, the component rate allocation  
18 in direct care shall be based upon actual facility occupancy.

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

25 (4)(a) Direct care component rate allocations shall be established  
26 using adjusted cost report data covering at least six months. Adjusted  
27 cost report data from 1996 will be used for October 1, 1998, through  
28 June 30, 2001, direct care component rate allocations; adjusted cost  
29 report data from 1999 will be used for July 1, 2001, through June 30,  
30 2006, direct care component rate allocations. Adjusted cost report  
31 data from 2003 will be used for July 1, 2006, (~~and later~~) through  
32 June 30, 2007, direct care component rate allocations. Adjusted cost  
33 report data from 2005 will be used for July 1, 2007, through June 30,  
34 2009, direct care component rate allocations. Effective July 1, 2009,  
35 the direct care component rate allocation shall be rebased biennially,  
36 and thereafter for each odd-numbered year beginning July 1st, using the  
37 adjusted cost report data for the calendar year two years immediately

1 preceding the rate rebase period, so that adjusted cost report data for  
2 calendar year 2007 is used for July 1, 2009, through June 30, 2011, and  
3 so forth.

4 (b) Direct care component rate allocations based on 1996 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 (c) Direct care component rate allocations based on 1999 cost  
13 report data shall be adjusted annually for economic trends and  
14 conditions by a factor or factors defined in the biennial  
15 appropriations act. A different economic trends and conditions  
16 adjustment factor or factors may be defined in the biennial  
17 appropriations act for facilities whose direct care component rate is  
18 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
19 74.46.506(5)(i).

20 (d) Direct care component rate allocations based on 2003 cost  
21 report data shall be adjusted annually for economic trends and  
22 conditions by a factor or factors defined in the biennial  
23 appropriations act. A different economic trends and conditions  
24 adjustment factor or factors may be defined in the biennial  
25 appropriations act for facilities whose direct care component rate is  
26 set equal to their adjusted June 30, 2006, rate, as provided in RCW  
27 74.46.506(5)(i).

28 (e) Direct care 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 (5)(a) Therapy care component rate allocations shall be established  
32 using adjusted cost report data covering at least six months. Adjusted  
33 cost report data from 1996 will be used for October 1, 1998, through  
34 June 30, 2001, therapy care component rate allocations; adjusted cost  
35 report data from 1999 will be used for July 1, 2001, through June 30,  
36 2005, therapy care component rate allocations. Adjusted cost report  
37 data from 1999 will continue to be used for July 1, 2005, ~~((and later))~~  
38 through June 30, 2007, therapy care component rate allocations.



1 Adjusted cost report data from 2005 will be used for July 1, 2007,  
2 through June 30, 2009, therapy care component rate allocations.  
3 Effective July 1, 2009, and thereafter for each odd-numbered year  
4 beginning July 1st, the therapy care component rate allocation shall be  
5 cost rebased biennially, using the adjusted cost report data for the  
6 calendar year two years immediately preceding the rate rebase period,  
7 so that adjusted cost report data for calendar year 2007 is used for  
8 July 1, 2009, through June 30, 2011, and so forth.

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

12 (6)(a) Support services component rate allocations shall be  
13 established using adjusted cost report data covering at least six  
14 months. Adjusted cost report data from 1996 shall be used for October  
15 1, 1998, through June 30, 2001, support services component rate  
16 allocations; adjusted cost report data from 1999 shall be used for July  
17 1, 2001, through June 30, 2005, support services component rate  
18 allocations. Adjusted cost report data from 1999 will continue to be  
19 used for July 1, 2005, (~~and later~~) through June 30, 2007, support  
20 services component rate allocations. Adjusted cost report data from  
21 2005 will be used for July 1, 2007, through June 30, 2009, support  
22 services component rate allocations. Effective July 1, 2009, and  
23 thereafter for each odd-numbered year beginning July 1st, the support  
24 services component rate allocation shall be cost rebased biennially,  
25 using the adjusted cost report data for the calendar year two years  
26 immediately preceding the rate rebase period, so that adjusted cost  
27 report data for calendar year 2007 is used for July 1, 2009, through  
28 June 30, 2011, and so forth.

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

32 (7)(a) Operations component rate allocations shall be established  
33 using adjusted cost report data covering at least six months. Adjusted  
34 cost report data from 1996 shall be used for October 1, 1998, through  
35 June 30, 2001, operations component rate allocations; adjusted cost  
36 report data from 1999 shall be used for July 1, 2001, through June 30,  
37 2006, operations component rate allocations. Adjusted cost report data  
38 from 2003 will be used for July 1, 2006, (~~and later~~) through June 30,

1 2007, operations component rate allocations. Adjusted cost report data  
2 from 2005 will be used for July 1, 2007, through June 30, 2009,  
3 operations component rate allocations. Effective July 1, 2009, and  
4 thereafter for each odd-numbered year beginning July 1st, the  
5 operations component rate allocation shall be cost rebased biennially,  
6 using the adjusted cost report data for the calendar year two years  
7 immediately preceding the rate rebase period, so that adjusted cost  
8 report data for calendar year 2007 is used for July 1, 2009, through  
9 June 30, 2011, and so forth.

10 (b) Operations component rate allocations shall be adjusted  
11 annually for economic trends and conditions by a factor or factors  
12 defined in the biennial appropriations act. A different economic  
13 trends and conditions adjustment factor or factors may be defined in  
14 the biennial appropriations act for facilities whose operations  
15 component rate is set equal to their adjusted June 30, 2006, rate, as  
16 provided in RCW 74.46.521(4).

17 (8) For July 1, 1998, through September 30, 1998, a facility's  
18 property and return on investment component rates shall be the  
19 facility's June 30, 1998, property and return on investment component  
20 rates, without increase. For October 1, 1998, through June 30, 1999,  
21 a facility's property and return on investment component rates shall be  
22 rebased utilizing 1997 adjusted cost report data covering at least six  
23 months of data.

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

27 (10) Medicaid contractors shall pay to all facility staff a minimum  
28 wage of the greater of the state minimum wage or the federal minimum  
29 wage.

30 (11) The department shall establish in rule procedures, principles,  
31 and conditions for determining component rate allocations for  
32 facilities in circumstances not directly addressed by this chapter,  
33 including but not limited to: The need to prorate inflation for  
34 partial-period cost report data, newly constructed facilities, existing  
35 facilities entering the medicaid program for the first time or after a  
36 period of absence from the program, existing facilities with expanded  
37 new bed capacity, existing medicaid facilities following a change of  
38 ownership of the nursing facility business, facilities banking beds or

1 converting beds back into service, facilities temporarily reducing the  
2 number of set-up beds during a remodel, facilities having less than six  
3 months of either resident assessment, cost report data, or both, under  
4 the current contractor prior to rate setting, and other circumstances.

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

10 (13) Effective July 1, 2001, medicaid rates shall continue to be  
11 revised downward in all components, in accordance with department  
12 rules, for facilities converting banked beds to active service under  
13 chapter 70.38 RCW, by using the facility's increased licensed bed  
14 capacity to recalculate minimum occupancy for rate setting. However,  
15 for facilities other than essential community providers which bank beds  
16 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be  
17 revised upward, in accordance with department rules, in direct care,  
18 therapy care, support services, and variable return components only, by  
19 using the facility's decreased licensed bed capacity to recalculate  
20 minimum occupancy for rate setting, but no upward revision shall be  
21 made to operations, property, or financing allowance component rates.  
22 The direct care component rate allocation shall be adjusted, without  
23 using the minimum occupancy assumption, for facilities that convert  
24 banked beds to active service, under chapter 70.38 RCW, beginning on  
25 July 1, 2006.

26 (14) Facilities obtaining a certificate of need or a certificate of  
27 need exemption under chapter 70.38 RCW after June 30, 2001, must have  
28 a certificate of capital authorization in order for (a) the  
29 depreciation resulting from the capitalized addition to be included in  
30 calculation of the facility's property component rate allocation; and  
31 (b) the net invested funds associated with the capitalized addition to  
32 be included in calculation of the facility's financing allowance rate  
33 allocation.

34 **Sec. 3.** RCW 74.46.506 and 2006 c 258 s 6 are each amended to read  
35 as follows:

36 (1) The direct care component rate allocation corresponds to the  
37 provision of nursing care for one resident of a nursing facility for

1 one day, including direct care supplies. Therapy services and  
2 supplies, which correspond to the therapy care component rate, shall be  
3 excluded. The direct care component rate includes elements of case mix  
4 determined consistent with the principles of this section and other  
5 applicable provisions of this chapter.

6 (2) Beginning October 1, 1998, the department shall determine and  
7 update quarterly for each nursing facility serving medicaid residents  
8 a facility-specific per-resident day direct care component rate  
9 allocation, to be effective on the first day of each calendar quarter.  
10 In determining direct care component rates the department shall  
11 utilize, as specified in this section, minimum data set resident  
12 assessment data for each resident of the facility, as transmitted to,  
13 and if necessary corrected by, the department in the resident  
14 assessment instrument format approved by federal authorities for use in  
15 this state.

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

23 (4) Cost report data used in setting direct care component rate  
24 allocations shall be (~~(1996, 1999, and 2003)~~) for rate periods as  
25 specified in RCW 74.46.431(4)(a).

26 (5) Beginning October 1, 1998, the department shall rebase each  
27 nursing facility's direct care component rate allocation as described  
28 in RCW 74.46.431, adjust its direct care component rate allocation for  
29 economic trends and conditions as described in RCW 74.46.431, and  
30 update its medicaid average case mix index, consistent with the  
31 following:

32 (a) Reduce total direct care costs reported by each nursing  
33 facility for the applicable cost report period specified in RCW  
34 74.46.431(4)(a) to reflect any department adjustments, and to eliminate  
35 reported resident therapy costs and adjustments, in order to derive the  
36 facility's total allowable direct care cost;

37 (b) Divide each facility's total allowable direct care cost by its  
38 adjusted resident days for the same report period, increased if

1 necessary to a minimum occupancy of eighty-five percent; that is, the  
2 greater of actual or imputed occupancy at eighty-five percent of  
3 licensed beds, to derive the facility's allowable direct care cost per  
4 resident day. However, effective July 1, 2006, each facility's  
5 allowable direct care costs shall be divided by its adjusted resident  
6 days without application of a minimum occupancy assumption;

7 (c) Adjust the facility's per resident day direct care cost by the  
8 applicable factor specified in RCW 74.46.431(4) (~~((b), (c), and (d))~~)  
9 to derive its adjusted allowable direct care cost per resident day;

10 (d) Divide each facility's adjusted allowable direct care cost per  
11 resident day by the facility average case mix index for the applicable  
12 quarters specified by RCW 74.46.501(7)(b) to derive the facility's  
13 allowable direct care cost per case mix unit;

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

18 (f) Array separately the allowable direct care cost per case mix  
19 unit for all facilities in nonurban counties; for all facilities in  
20 high labor-cost counties, if applicable; and for all facilities in  
21 other urban counties, and determine the median allowable direct care  
22 cost per case mix unit for each peer group;

23 (g) Except as provided in (i) of this subsection, from October 1,  
24 1998, through June 30, 2000, determine each facility's quarterly direct  
25 care component rate as follows:

26 (i) Any facility whose allowable cost per case mix unit is less  
27 than eighty-five percent of the facility's peer group median  
28 established under (f) of this subsection shall be assigned a cost per  
29 case mix unit equal to eighty-five percent of the facility's peer group  
30 median, and shall have a direct care component rate allocation equal to  
31 the facility's assigned cost per case mix unit multiplied by that  
32 facility's medicaid average case mix index from the applicable quarter  
33 specified in RCW 74.46.501(7)(c);

34 (ii) Any facility whose allowable cost per case mix unit is greater  
35 than one hundred fifteen percent of the peer group median established  
36 under (f) of this subsection shall be assigned a cost per case mix unit  
37 equal to one hundred fifteen percent of the peer group median, and  
38 shall have a direct care component rate allocation equal to the

1 facility's assigned cost per case mix unit multiplied by that  
2 facility's medicaid average case mix index from the applicable quarter  
3 specified in RCW 74.46.501(7)(c);

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

10 (h) Except as provided in (i) of this subsection, from July 1,  
11 2000, through June 30, 2006, determine each facility's quarterly direct  
12 care component rate as follows:

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

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

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

35 (i)(i) Between October 1, 1998, and June 30, 2000, the department  
36 shall compare each facility's direct care component rate allocation  
37 calculated under (g) of this subsection with the facility's nursing  
38 services component rate in effect on September 30, 1998, less therapy

1 costs, plus any exceptional care offsets as reported on the cost  
2 report, adjusted for economic trends and conditions as provided in RCW  
3 74.46.431. A facility shall receive the higher of the two rates.

4 (ii) Between July 1, 2000, and June 30, 2002, the department shall  
5 compare each facility's direct care component rate allocation  
6 calculated under (h) of this subsection with the facility's direct care  
7 component rate in effect on June 30, 2000. A facility shall receive  
8 the higher of the two rates. Between July 1, 2001, and June 30, 2002,  
9 if during any quarter a facility whose rate paid under (h) of this  
10 subsection is greater than either the direct care rate in effect on  
11 June 30, 2000, or than that facility's allowable direct care cost per  
12 case mix unit calculated in (d) of this subsection multiplied by that  
13 facility's medicaid average case mix index from the applicable quarter  
14 specified in RCW 74.46.501(7)(c), the facility shall be paid in that  
15 and each subsequent quarter pursuant to (h) of this subsection and  
16 shall not be entitled to the greater of the two rates.

17 (iii) Between July 1, 2002, and June 30, 2006, all direct care  
18 component rate allocations shall be as determined under (h) of this  
19 subsection.

20 (iv) Effective July 1, 2006, for all providers, except vital local  
21 providers as defined in this chapter, all direct care component rate  
22 allocations shall be as determined under (j) of this subsection.

23 (v) Effective July 1, 2006, through June 30, 2007, for vital local  
24 providers, as defined in this chapter, direct care component rate  
25 allocations shall be determined as follows:

26 (A) The department shall calculate:

27 (I) The sum of each facility's July 1, 2006, direct care component  
28 rate allocation calculated under (j) of this subsection and July 1,  
29 2006, operations component rate calculated under RCW 74.46.521; and

30 (II) The sum of each facility's June 30, 2006, direct care and  
31 operations component rates.

32 (B) If the sum calculated under (i)(v)(A)(I) of this subsection is  
33 less than the sum calculated under (i)(v)(A)(II) of this subsection,  
34 the facility shall have a direct care component rate allocation equal  
35 to the facility's June 30, 2006, direct care component rate allocation.

36 (C) If the sum calculated under (i)(v)(A)(I) of this subsection is  
37 greater than or equal to the sum calculated under (i)(v)(A)(II) of this

1 subsection, the facility's direct care component rate shall be  
2 calculated under (j) of this subsection;

3 (j) Except as provided in (i) of this subsection, from July 1,  
4 2006, forward, and for all future rate setting, determine each  
5 facility's quarterly direct care component rate as follows:

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

14 (ii) Any facility whose allowable cost per case mix unit is less  
15 than or equal to one hundred twelve percent of the peer group median  
16 established under (f) of this subsection shall have a direct care  
17 component rate allocation equal to the facility's allowable cost per  
18 case mix unit multiplied by that facility's medicaid average case mix  
19 index from the applicable quarter specified in RCW 74.46.501(7)(c).

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

23 (7) Costs related to payments resulting from increases in direct  
24 care component rates, granted under authority of RCW 74.46.508(1) for  
25 a facility's exceptional care residents, shall be offset against the  
26 facility's examined, allowable direct care costs, for each report year  
27 or partial period such increases are paid. Such reductions in  
28 allowable direct care costs shall be for rate setting, settlement, and  
29 other purposes deemed appropriate by the department.

30 **Sec. 4.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended  
31 to read as follows:

32 (1) The therapy care component rate allocation corresponds to the  
33 provision of medicaid one-on-one therapy provided by a qualified  
34 therapist as defined in this chapter, including therapy supplies and  
35 therapy consultation, for one day for one medicaid resident of a  
36 nursing facility. The therapy care component rate allocation for  
37 October 1, 1998, through June 30, 2001, shall be based on adjusted



1 therapy costs and days from calendar year 1996. The therapy component  
2 rate allocation for July 1, 2001, through June 30, (~~2004~~) 2007, shall  
3 be based on adjusted therapy costs and days from calendar year 1999.  
4 Effective July 1, 2007, the therapy care component rate allocation  
5 shall be based on adjusted therapy costs and days as described in RCW  
6 74.46.431(5). The therapy care component rate shall be adjusted for  
7 economic trends and conditions as specified in RCW 74.46.431(5)(~~b~~),  
8 and shall be determined in accordance with this section.

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

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

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

18 (c) Therapy consulting expenses for all residents.

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

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

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

26 (b) Those located within nonurban counties.

27 The department shall array the facilities in each peer group from  
28 highest to lowest based on their total cost per unit of therapy for  
29 each therapy type. The department shall determine the median total  
30 cost per unit of therapy for each therapy type and add ten percent of  
31 median total cost per unit of therapy. The cost per unit of therapy  
32 for each therapy type at a nursing facility shall be the lesser of its  
33 cost per unit of therapy for each therapy type or the median total cost  
34 per unit plus ten percent for each therapy type for its peer group.

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

37 (a) To determine the allowable total therapy cost for each therapy

1 type, the allowable cost per unit of therapy for each type of therapy  
2 shall be multiplied by the total therapy units for each type of  
3 therapy;

4 (b) The medicaid allowable one-on-one therapy expense shall be  
5 calculated taking the allowable total therapy cost for each therapy  
6 type times the medicaid percent of total therapy charges for each  
7 therapy type;

8 (c) The medicaid allowable one-on-one therapy expense for each  
9 therapy type shall be divided by total adjusted medicaid days to arrive  
10 at the medicaid one-on-one therapy cost per patient day for each  
11 therapy type;

12 (d) The medicaid one-on-one therapy cost per patient day for each  
13 therapy type shall be multiplied by total adjusted patient days for all  
14 residents to calculate the total allowable one-on-one therapy expense.  
15 The lesser of the total allowable therapy consultant expense for the  
16 therapy type or a reasonable percentage of allowable therapy consultant  
17 expense for each therapy type, as established in rule by the  
18 department, shall be added to the total allowable one-on-one therapy  
19 expense to determine the allowable therapy cost for each therapy type;

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

23 (f) The total allowable therapy expense will be divided by the  
24 greater of adjusted total patient days from the cost report on which  
25 the therapy expenses were reported, or patient days at eighty-five  
26 percent occupancy of licensed beds. The outcome shall be the nursing  
27 facility's therapy care component rate allocation.

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

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

35 **Sec. 5.** RCW 74.46.521 and 2006 c 258 s 7 are each amended to read  
36 as follows:

37 (1) The operations component rate allocation corresponds to the

1 general operation of a nursing facility for one resident for one day,  
2 including but not limited to management, administration, utilities,  
3 office supplies, accounting and bookkeeping, minor building  
4 maintenance, minor equipment repairs and replacements, and other  
5 supplies and services, exclusive of direct care, therapy care, support  
6 services, property, financing allowance, and variable return.

7 (2) Except as provided in subsection (4) of this section, beginning  
8 October 1, 1998, the department shall determine each medicaid nursing  
9 facility's operations component rate allocation using cost report data  
10 specified by RCW 74.46.431(7)(a). Effective July 1, 2002, operations  
11 component rates for all facilities except essential community providers  
12 shall be based upon a minimum occupancy of ninety percent of licensed  
13 beds, and no operations component rate shall be revised in response to  
14 beds banked on or after May 25, 2001, under chapter 70.38 RCW.

15 (3) Except as provided in subsection (4) of this section, to  
16 determine each facility's operations component rate the department  
17 shall:

18 (a) Array facilities' adjusted general operations costs per  
19 adjusted resident day, as determined by dividing each facility's total  
20 allowable operations cost by its adjusted resident days for the same  
21 report period, increased if necessary to a minimum occupancy of ninety  
22 percent; that is, the greater of actual or imputed occupancy at ninety  
23 percent of licensed beds, for each facility from facilities' cost  
24 reports from the applicable report year, for facilities located within  
25 urban counties and for those located within nonurban counties and  
26 determine the median adjusted cost for each peer group;

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

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

32 (ii) The adjusted median per resident day general operations cost  
33 for that facility's peer group, urban counties or nonurban counties;  
34 and

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

37 (4)(a) Effective July 1, 2006, through June 30, 2007, for any  
38 facility whose direct care component rate allocation is set equal to

1 its June 30, 2006, direct care component rate allocation, as provided  
2 in RCW 74.46.506(5)((+i)), the facility's operations component rate  
3 allocation shall also be set equal to the facility's June 30, 2006,  
4 operations component rate allocation.

5 (b) The operations component rate allocation for facilities whose  
6 operations component rate is set equal to their June 30, 2006,  
7 operations component rate, shall be adjusted for economic trends and  
8 conditions as provided in RCW 74.46.431(7)(b).

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

12 NEW SECTION. **Sec. 6.** A new section is added to chapter 74.46 RCW  
13 to read as follows:

14 (1) For the purposes of comparison, the department shall determine  
15 the following during the rate-setting periods for fiscal years 2008 and  
16 2009:

17 (a) Each facility's June 30, 2007, combined rate for the direct  
18 care, support services, therapy, and operations components, less the  
19 quality maintenance fee; and

20 (b) Each facility's estimated rebased rates for the July 1, 2007,  
21 and July 1, 2008, rate-setting periods, for the direct care, support  
22 services, therapy, and operations rate components, less the quality  
23 maintenance fee, adjusted for economic trends and conditions under the  
24 2007-2009 biennial appropriations act.

25 (2) For the 2007-2009 fiscal biennium, the department shall include  
26 a "hold harmless" provision after rebasing to 2005 costs for the July  
27 1, 2007, through June 30, 2008, rate-setting period and the July 1,  
28 2008, through June 30, 2009, rate-setting period. This "hold harmless"  
29 provision shall apply to facilities that meet both of the following  
30 conditions:

31 (a) Facilities whose estimated rebased rates calculated under  
32 subsection (1)(b) of this section are less than their June 30, 2007,  
33 rates calculated under subsection (1)(a) of this section; and

34 (b) Facilities whose combined adjusted costs per adjusted resident  
35 day in the direct care, support services, therapy, and operations cost  
36 centers were greater than the combined per resident day reimbursement  
37 rates for these cost centers in either calendar years 2004 or 2005.

1 For those facilities that meet the conditions in this subsection,  
2 the "hold harmless" provision shall ensure that for the July 1, 2007,  
3 through June 30, 2008, rate-setting period and for the July 1, 2008,  
4 through June 30, 2009, rate-setting period, the department shall set  
5 each facility's component rates in direct care, support services,  
6 therapy, and operations to the facility's June 30, 2007, rate, less the  
7 quality maintenance fee, adjusted for economic trends and conditions  
8 specified in the 2007-2009 biennial appropriations act.

9 **Sec. 7.** RCW 74.46.020 and 2006 c 258 s 1 are each amended to read  
10 as follows:

11 Unless the context clearly requires otherwise, the definitions in  
12 this section apply throughout this chapter.

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

17 (2) "Appraisal" means the process of estimating the fair market  
18 value or reconstructing the historical cost of an asset acquired in a  
19 past period as performed by a professionally designated real estate  
20 appraiser with no pecuniary interest in the property to be appraised.  
21 It includes a systematic, analytic determination and the recording and  
22 analyzing of property facts, rights, investments, and values based on  
23 a personal inspection and inventory of the property.

24 (3) "Arm's-length transaction" means a transaction resulting from  
25 good-faith bargaining between a buyer and seller who are not related  
26 organizations and have adverse positions in the market place. Sales or  
27 exchanges of nursing home facilities among two or more parties in which  
28 all parties subsequently continue to own one or more of the facilities  
29 involved in the transactions shall not be considered as arm's-length  
30 transactions for purposes of this chapter. Sale of a nursing home  
31 facility which is subsequently leased back to the seller within five  
32 years of the date of sale shall not be considered as an arm's-length  
33 transaction for purposes of this chapter.

34 (4) "Assets" means economic resources of the contractor, recognized  
35 and measured in conformity with generally accepted accounting  
36 principles.

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

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

9 (7) "Beneficial owner" means:

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

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

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

16 (b) Any person who, directly or indirectly, creates or uses a  
17 trust, proxy, power of attorney, pooling arrangement, or any other  
18 contract, arrangement, or device with the purpose or effect of  
19 divesting himself or herself of beneficial ownership of an ownership  
20 interest or preventing the vesting of such beneficial ownership as part  
21 of a plan or scheme to evade the reporting requirements of this  
22 chapter;

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

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

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

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

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

32 except that, any person who acquires an ownership interest or power  
33 specified in (c)(i), (ii), or (iii) of this subsection with the purpose  
34 or effect of changing or influencing the control of the contractor, or  
35 in connection with or as a participant in any transaction having such  
36 purpose or effect, immediately upon such acquisition shall be deemed to  
37 be the beneficial owner of the ownership interest which may be acquired  
38 through the exercise or conversion of such ownership interest or power;

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

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

13 (ii) The pledgee agreement, prior to default, does not grant to the  
14 pledgee:

15 (A) The power to vote or to direct the vote of the pledged  
16 ownership interest; or

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

21 (8) "Capitalization" means the recording of an expenditure as an  
22 asset.

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

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

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

31 (12) "Certificate of capital authorization" means a certification  
32 from the department for an allocation from the biennial capital  
33 financing authorization for all new or replacement building  
34 construction, or for major renovation projects, receiving a certificate  
35 of need or a certificate of need exemption under chapter 70.38 RCW  
36 after July 1, 2001.

37 (13) "Contractor" means a person or entity licensed under chapter  
38 18.51 RCW to operate a medicare and medicaid certified nursing

1 facility, responsible for operational decisions, and contracting with  
2 the department to provide services to medicaid recipients residing in  
3 the facility.

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

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

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

13 (17) "Direct care" means nursing care and related care provided to  
14 nursing facility residents. Therapy care shall not be considered part  
15 of direct care.

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

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

22 (20) "Equity" means the net book value of all tangible and  
23 intangible assets less the recorded value of all liabilities, as  
24 recognized and measured in conformity with generally accepted  
25 accounting principles.

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

29 (22) "Facility" or "nursing facility" means a nursing home licensed  
30 in accordance with chapter 18.51 RCW, excepting nursing homes certified  
31 as institutions for mental diseases, or that portion of a multiservice  
32 facility licensed as a nursing home, or that portion of a hospital  
33 licensed in accordance with chapter 70.41 RCW which operates as a  
34 nursing home.

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



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

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

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

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

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

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

21 (30) "Home and central office costs" means costs that are incurred  
22 in the support and operation of a home and central office. Home and  
23 central office costs include centralized services that are performed in  
24 support of a nursing facility. The department may exclude from this  
25 definition costs that are nonduplicative, documented, ordinary,  
26 necessary, and related to the provision of care services to authorized  
27 patients.

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

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

33 (33) "Lease agreement" means a contract between two parties for the  
34 possession and use of real or personal property or assets for a  
35 specified period of time in exchange for specified periodic payments.  
36 Elimination (due to any cause other than death or divorce) or addition  
37 of any party to the contract, expiration, or modification of any lease  
38 term in effect on January 1, 1980, or termination of the lease by

1 either party by any means shall constitute a termination of the lease  
2 agreement. An extension or renewal of a lease agreement, whether or  
3 not pursuant to a renewal provision in the lease agreement, shall be  
4 considered a new lease agreement. A strictly formal change in the  
5 lease agreement which modifies the method, frequency, or manner in  
6 which the lease payments are made, but does not increase the total  
7 lease payment obligation of the lessee, shall not be considered  
8 modification of a lease term.

9 (34) "Medical care program" or "medicaid program" means medical  
10 assistance, including nursing care, provided under RCW 74.09.500 or  
11 authorized state medical care services.

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

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

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

20 (38) "Net invested funds" means the net book value of tangible  
21 fixed assets employed by a contractor to provide services under the  
22 medical care program, including land, buildings, and equipment as  
23 recognized and measured in conformity with generally accepted  
24 accounting principles.

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

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

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

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

1 (43) "Patient day" or "resident day" means a calendar day of care  
2 provided to a nursing facility resident, regardless of payment source,  
3 which will include the day of admission and exclude the day of  
4 discharge; except that, when admission and discharge occur on the same  
5 day, one day of care shall be deemed to exist. A "medicaid day" or  
6 "recipient day" means a calendar day of care provided to a medicaid  
7 recipient determined eligible by the department for services provided  
8 under chapter 74.09 RCW, subject to the same conditions regarding  
9 admission and discharge applicable to a patient day or resident day of  
10 care.

11 (44) "Professionally designated real estate appraiser" means an  
12 individual who is regularly engaged in the business of providing real  
13 estate valuation services for a fee, and who is deemed qualified by a  
14 nationally recognized real estate appraisal educational organization on  
15 the basis of extensive practical appraisal experience, including the  
16 writing of real estate valuation reports as well as the passing of  
17 written examinations on valuation practice and theory, and who by  
18 virtue of membership in such organization is required to subscribe and  
19 adhere to certain standards of professional practice as such  
20 organization prescribes.

21 (45) "Qualified therapist" means:

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

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

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

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

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

34 (f) A respiratory care practitioner certified under chapter 18.89  
35 RCW.

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

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

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

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

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

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

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

24 (51) "Related care" means only those services that are directly  
25 related to providing direct care to nursing facility residents. These  
26 services include, but are not limited to, nursing direction and  
27 supervision, medical direction, medical records, pharmacy services,  
28 activities, and social services.

29 (52) "Resident assessment instrument," including federally approved  
30 modifications for use in this state, means a federally mandated,  
31 comprehensive nursing facility resident care planning and assessment  
32 tool, consisting of the minimum data set and resident assessment  
33 protocols.

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

37 (54) "Resource utilization groups" means a case mix classification

1 system that identifies relative resources needed to care for an  
2 individual nursing facility resident.

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

6 (56) "Secretary" means the secretary of the department of social  
7 and health services.

8 (57) "Support services" means food, food preparation, dietary,  
9 housekeeping, and laundry services provided to nursing facility  
10 residents.

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

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

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

22 (61) "Vital local provider" means a facility (~~(reporting a home~~  
23 ~~office))~~) that meets the following qualifications:

24 (a) (~~The~~) It reports a home office with an address (~~(is)~~) located  
25 in Washington state; and

26 (b) The sum of medicaid days for all Washington facilities  
27 reporting (~~the~~) that home office as their home office was greater  
28 than two hundred fifteen thousand in 2003; and

29 (c) The facility was recognized as a "vital local provider" by the  
30 department as of April 1, 2007.

31 The definition of "vital local provider" shall expire, and have no  
32 force or effect, after June 30, 2007. After that date, no facility's  
33 payments under this chapter shall in any way be affected by its prior  
34 determination or recognition as a vital local provider.

35 NEW SECTION. Sec. 8. This act is necessary for the immediate  
36 preservation of the public peace, health, or safety, or support of the

1 state government and its existing public institutions, and takes effect  
2 July 1, 2007.

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