1484-S2.E AAS 4/21/99 S2699.6

E2SHB 1484 - S COMM AMD
By Committee on Ways & Means

ADOPTED 4/21/99

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 74.46.020 and 1998 c 322 s 2 are each amended to read as follows:

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

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

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

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

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

(5) "Audit" or "department audit" means an examination of the records of a nursing facility participating in the medicaid payment

system, including but not limited to: The contractor's financial and statistical records, cost reports and all supporting documentation and schedules, receivables, and resident trust funds, to be performed as deemed necessary by the department and according to department rule.

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

(7) "Beneficial owner" means:

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

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

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

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

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

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

(ii) Through the conversion of an ownership interest;

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

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

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

(d) Any person who in the ordinary course of business is a pledgee of ownership interest under a written pledge agreement shall not be deemed to be the beneficial owner of such pledged ownership interest

until the pledgee has taken all formal steps necessary which are required to declare a default and determines that the power to vote or to direct the vote or to dispose or to direct the disposition of such pledged ownership interest will be exercised; except that:

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

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

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

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

(8) "Capital portion of the rate" means the sum of the property and financing allowance rate allocations, as established in part E of this chapter.

(9) "Capitalization" means the recording of an expenditure as an asset.

((~~(9)~~)) (10) "Case mix" means a measure of the intensity of care and services needed by the residents of a nursing facility or a group of residents in the facility.

((~~(10)~~)) (11) "Case mix index" means a number representing the average case mix of a nursing facility.

((~~(11)~~)) (12) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility’s residents.

((~~(12)~~)) (13) "Contractor" means a person or entity licensed under chapter 18.51 RCW to operate a medicare and medicaid certified nursing facility, responsible for operational decisions, and contracting with the department to provide services to medicaid recipients residing in the facility.

((~~(13)~~)) (14) "Default case" means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

((~~(14)~~)) (15) "Department" means the department of social and health services (DSHS) and its employees.

((~~(15)~~)) (16) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

((~~(16)~~)) (17) "Direct care" means nursing care and related care provided to nursing facility residents. Therapy care shall not be considered part of direct care.

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

((~~(18)~~)) (19) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(19)~~)) (20) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

((~~(20)~~)) (21) "Facility" or "nursing facility" means a nursing home licensed in accordance with chapter 18.51 RCW, excepting nursing homes certified as institutions for mental diseases, or that portion of a multiservice facility licensed as a nursing home, or that portion of a hospital licensed in accordance with chapter 70.41 RCW which operates as a nursing home.

((~~(21)~~)) (22) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

((~~(22)~~)) (23) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

((~~(23)~~)) (24) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB).

((~~(24)~~)) (25) "Goodwill" means the excess of the price paid for a nursing facility business over the fair market value of all net identifiable tangible and intangible assets acquired, as measured in accordance with generally accepted accounting principles.

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

((~~(26)~~)) (27) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

((~~(27)~~)) (28) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

((~~(28)~~)) (29) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(29)~~)) (30) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

((~~(30)~~)) (31) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

((~~(31)~~)) (32) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(32)~~)) (33) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

((~~(33)~~)) (34) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(34)~~)) (35) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services

under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles((~~, plus an allowance for working capital which shall be five percent of the product of the per patient day rate multiplied by the prior calendar year reported total patient days of each contractor~~)).

((~~(35)~~)) (36) "Noncapital portion of the rate" means the sum of the direct care, therapy care, operations, support services, and variable return rate allocations, as established in part E of this chapter.

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

((~~(36)~~)) (38) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(37)~~)) (39) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(38)~~)) (40) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(39)~~)) (41) "Professionally designated real estate appraiser" means an individual who is regularly engaged in the business of providing real estate valuation services for a fee, and who is deemed qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience, including the writing of real estate valuation reports as well as the passing of written examinations on valuation practice and theory, and who by virtue of membership in such organization is required to subscribe and adhere to certain standards of professional practice as such organization prescribes.

((~~(40)~~)) (42) "Qualified therapist" means:

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

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

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

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

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

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

((~~(41)~~)) (43) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in part E of this chapter.

((~~(42)~~)) (44) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

((~~(43)~~)) (45) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(44)~~)) (46) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(45)~~)) (47) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor.

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

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

((~~(46)~~)) (48) "Related care" means only those services that are directly related to providing direct care to nursing facility residents. These services include, but are not limited to, nursing direction and supervision, medical direction, medical records, pharmacy services, activities, and social services.

((~~(47)~~)) (49) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(48)~~)) (50) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

((~~(49)~~)) (51) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(50)~~)) (52) "Restricted fund" means those funds the principal and/or income of which is limited by agreement with or direction of the donor to a specific purpose.

((~~(51)~~)) (53) "Secretary" means the secretary of the department of social and health services.

((~~(52)~~)) (54) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

((~~(53)~~)) (55) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

((~~(54)~~)) (56) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

Sec. 2. RCW 74.46.360 and 1997 c 277 s 1 are each amended to read as follows:

(1) For all partial or whole rate periods after December 31, 1984, the cost basis of land and depreciation base of depreciable assets shall be the historical cost of the contractor or lessor, when the assets are leased by the contractor, in acquiring the asset in an arm's-length transaction and preparing it for use, less goodwill, and less accumulated depreciation, if applicable, which has been incurred during periods that the assets have been used in or as a facility by any contractor, such accumulated depreciation to be measured in accordance with subsections (4), (5), and (6) of this section and RCW 74.46.350 and 74.46.370. If the department challenges the historical cost of an asset, or if the contractor cannot or will not provide the historical costs, the department will have the department of general administration, through an appraisal procedure, determine the fair market value of the assets at the time of purchase. The cost basis of land and depreciation base of depreciable assets will not exceed such fair market value.

(2) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall determine allowable land costs of the additional land acquired for the replacement construction or building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the Uniform Standards of Professional Appraisal Practice (USPAP) and the financial institutions reform, recovery, and enhancement act (FIRREA).

(3) Subject to the provisions of subsection (2) of this section, if, in the course of financing a project, an arm's-length lender has ordered a Uniform Standards of Professional Appraisal Practice appraisal on the land that meets financial institutions reform, recovery, and enhancement act standards and the arm's-length lender has accepted the ordered appraisal, the department shall accept the appraisal value as allowable land costs for calculation of payment.

If the contractor or lessor is unable or unwilling to provide or cause to be provided to the department, or the department is unable to obtain from the arm's-length lender, a lender-approved appraisal that meets the standards of the Uniform Standards of Professional Appraisal

Practice and financial institutions reform, recovery, and enhancement act, the department shall order such an appraisal and accept the appraisal as the allowable land costs. If the department orders the Uniform Standards of Professional Appraisal Practice and financial institutions reform, recovery, and enhancement act appraisal, the contractor shall immediately reimburse the department for the costs incurred.

(4) The historical cost of depreciable and nondepreciable donated assets, or of depreciable and nondepreciable assets received through testate or intestate distribution, shall be the lesser of:

(a) Fair market value at the date of donation or death; or

(b) The historical cost base of the owner last contracting with the department, if any.

(5) Estimated salvage value of acquired, donated, or inherited assets shall be deducted from historical cost where the straight-line or sum-of-the-years' digits method of depreciation is used.

(6)(a) For facilities, other than those described under subsection (2) of this section, operating prior to July 1, 1997, where land or depreciable assets are acquired that were used in the medical care program subsequent to January 1, 1980, the cost basis or depreciation base of the assets will not exceed the net book value which did exist or would have existed had the assets continued in use under the previous contract with the department; except that depreciation shall not be assumed to accumulate during periods when the assets were not in use in or as a facility.

(b) The provisions of (a) of this subsection shall not apply to the most recent arm's-length acquisition if it occurs at least ten years after the ownership of the assets has been previously transferred in an arm's-length transaction nor to the first arm's-length acquisition that occurs after January 1, 1980, for facilities participating in the medical care program prior to January 1, 1980. The new cost basis or depreciation base for such acquisitions shall not exceed the fair market value of the assets as determined by the department of general administration through an appraisal procedure. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such determination is shown to be arbitrary and capricious. For all partial or whole rate periods after July 17, 1984, this subsection is inoperative for any transfer of ownership of any asset, depreciable or nondepreciable, occurring on or

after July 18, 1984, leaving (a) of this subsection to apply alone to such transfers: PROVIDED, HOWEVER, That this subsection shall apply to transfers of ownership of assets occurring prior to January 1, 1985, if the costs of such assets have never been reimbursed under medicaid cost reimbursement on an owner-operated basis or as a related-party lease: PROVIDED FURTHER, That for any contractor that can document in writing an enforceable agreement for the purchase of a nursing home dated prior to July 18, 1984, and submitted to the department prior to January 1, 1988, the cost basis of allowable land and the depreciation base of the nursing home, for rates established after July 18, 1984, shall not exceed the fair market value of the assets at the date of purchase as determined by the department of general administration through an appraisal procedure. For medicaid cost reimbursement purposes, an agreement to purchase a nursing home dated prior to July 18, 1984, is enforceable, even though such agreement contains no legal description of the real property involved, notwithstanding the statute of frauds or any other provision of law.

(c) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option:

(i) To have the provisions of subsection (b) of this section apply to the purchase; or

(ii) To have the reimbursement for property and ((~~return on investment continue to be~~)) financing allowance calculated pursuant to ((~~the provisions contained in RCW 74.46.530(1) (e) and (f)~~)) this chapter based upon the provisions of the lease in existence on the date of the purchase, but only if the purchase date meets one of the following criteria:

(A) The purchase date is after the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(B) The purchase date is within one year of the lease expiration or renewal date contained in the lease;

(C) The purchase date is after a rate setting for the facility in which the reimbursement rate set pursuant to this chapter no longer is equal to or greater than the actual cost of the lease; or

(D) The purchase date is within one year of any purchase option in existence on January 1, 1988.

(d) For all rate periods past or future where land or depreciable assets are acquired from a related organization, the contractor's cost basis and depreciation base shall not exceed the base the related organization had or would have had under a contract with the department.

(e) Where the land or depreciable asset is a donation or distribution between related organizations, the cost basis or depreciation base shall be the lesser of (i) fair market value, less salvage value, or (ii) the cost basis or depreciation base the related organization had or would have had for the asset under a contract with the department.

Sec. 3. RCW 74.46.421 and 1998 c 322 s 18 are each amended to read as follows:

(1) The purpose of part E of this chapter is to determine nursing facility medicaid payment rates that, in the aggregate for all participating nursing facilities, are in accordance with the biennial appropriations act.

(2)(a) The department shall use the nursing facility medicaid payment rate methodologies described in this chapter to determine initial component rate allocations for each medicaid nursing facility.

(b) The initial component rate allocations shall be subject to adjustment as provided in this section in order to assure that the state-wide average payment rate to nursing facilities is less than or equal to the state-wide average payment rate specified in the biennial appropriations act.

(3) Nothing in this chapter shall be construed as creating a legal right or entitlement to any payment that (a) has not been adjusted under this section or (b) would cause the state-wide average payment rate to exceed the state-wide average payment rate specified in the biennial appropriations act.

(4)(a) The state-wide average payment rate <u>for the capital portion of the rate</u> for any state fiscal year under the nursing facility medicaid payment system, weighted by patient days, shall not exceed the annual state-wide weighted average nursing facility payment rate <u>for the capital portion of the rate</u> identified for that fiscal year in the biennial appropriations act.

(b) If the department determines that the weighted average nursing facility payment rate <u>for the capital portion of the rate</u> calculated in

accordance with this chapter is likely to exceed the weighted average nursing facility payment rate for the capital portion of the rate identified in the biennial appropriations act, then the department shall adjust all nursing facility property and financing allowance payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted capital portion of the rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each component rate allocation for each facility.

(5)(a) The state-wide average payment rate for the noncapital portion of the rate for any state fiscal year under the nursing facility payment system, weighted by patient days, shall not exceed the annual state-wide weighted average nursing facility payment rate for the noncapital portion of the rate identified for that fiscal year in the biennial appropriations act.

(b) If the department determines that the weighted average nursing facility payment rate for the noncapital portion of the rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate for the noncapital portion of the rate identified in the biennial appropriations act, then the department shall adjust all nursing facility direct care, therapy care, support services, operations, and variable return payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted noncapital portion of the rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each direct care, therapy care, support services, operations, and variable return rate allocation for each facility.

Sec. 4. RCW 74.46.431 and 1998 c 322 s 19 are each amended to read as follows:

(1) Effective ((~~October 1, 1998~~)) July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have ((~~six~~)) seven components: Direct care, therapy care, support services, operations, property, financing allowance, and variable return ((~~on investment~~)). The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) All component rate allocations shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use.

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

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

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

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

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

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

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

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

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

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

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

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

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of five dollars and fifteen cents per hour or the federal minimum wage.

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for

partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

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

Sec. 5. RCW 74.46.506 and 1998 c 322 s 25 are each amended to read as follows:

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

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

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

to obtain compliance with resident assessment and data transmission requirements and to ensure accuracy.

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

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

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

(b) Divide each facility's total allowable direct care cost by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy of eighty-five percent; that is, the greater of actual or imputed occupancy at eighty-five percent of licensed beds, to derive the facility's allowable direct care cost per resident day;

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

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

(e) Divide nursing facilities into two peer groups: Those located in metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area;

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

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

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

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

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

(h) Except as provided in (k) of this subsection, from July 1, 2000, through June 30, 2002, determine each facility's quarterly direct care component rate as follows:

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

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred ten percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal

to one hundred ten percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

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

(i) From July 1, 2002, through June 30, 2004, determine each facility's quarterly direct care component rate as follows:

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

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

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

(j) Beginning July 1, 2004, determine each facility's quarterly direct care component rate by multiplying the facility's peer group median allowable direct care cost per case mix unit by that facility's

medicaid average case mix index from the applicable quarter as specified in RCW 74.46.501(7)(c).

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

(ii) Between July 1, 2000, and June 30, 2002, the department shall compare each facility's direct care component rate allocation calculated under (h) of this subsection with the facility's direct care component rate in effect on June 30, 2000. A facility shall receive the higher of the two rates.

(6) The direct care component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. ((~~If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.~~))

Sec. 6. RCW 74.46.511 and 1998 c 322 s 26 are each amended to read as follows:

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

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

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

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

(c) Therapy consulting expenses for all residents.

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

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

(a) Those facilities located within a metropolitan statistical area; and

(b) Those not located in a metropolitan statistical area.

Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States office of management and budget or other applicable federal office. The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

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

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

(b) The medicaid allowable one-on-one therapy expense shall be calculated taking the allowable total therapy cost for each therapy

type times the medicaid percent of total therapy charges for each therapy type;

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

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

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

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

(6) The therapy care component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. ((~~If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.~~))

Sec. 7. RCW 74.46.515 and 1998 c 322 s 27 are each amended to read as follows:

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

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

(3) To determine each facility's support services component rate allocation, the department shall:

(a) Array facilities' adjusted support services costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area, and for those not located in any metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either metropolitan statistical area or nonmetropolitan statistical area, plus ten percent; and

(c) Adjust each facility's support services component rate for economic trends and conditions as provided in RCW 74.46.431(6).

(4) The support services component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. ((~~If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.~~))

Sec. 8. RCW 74.46.521 and 1998 c 322 s 28 are each amended to read as follows:

(1) The operations component rate allocation corresponds to the general operation of a nursing facility for one resident for one day, including but not limited to management, administration, utilities, office supplies, accounting and bookkeeping, minor building maintenance, minor equipment repairs and replacements, and other supplies and services, exclusive of direct care, therapy care, support

services, property, financing allowance, and variable return ((~~on investment~~)).

(2) Beginning October 1, 1998, the department shall determine each medicaid nursing facility's operations component rate allocation using cost report data specified by RCW 74.46.431(7)(a).

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

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area and for those not located in a metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's operations component rate at the lower of the facility's per resident day adjusted operations costs from the applicable cost report period or the adjusted median per resident day general operations cost for that facility's peer group, metropolitan statistical area or nonmetropolitan statistical area; and

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

(4) The operations component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. ((~~If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.~~))

NEW SECTION. **Sec. 9.** (1) The department shall establish for each medicaid nursing facility a variable return component rate allocation. In determining the variable return allowance:

(a) The variable return array and percentage assigned at the October 1, 1998, rate setting shall remain in effect until June 30, 2001.

(b) The department shall then compute the variable return allowance by multiplying the appropriate percentage amounts, which shall not be

less than one percent and not greater than four percent, by the sum of the facility's direct care, therapy care, support services, and operations rate components. The percentage amounts will be based on groupings of facilities according to the rankings prescribed in (a) of this subsection, as applicable. Those groups of facilities with lower per diem costs shall receive higher percentage amounts than those with higher per diem costs.

(2) The variable return rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

Sec. 10. 1998 c 322 s 29 (uncodified) is amended to read as follows:

(1) The property component rate allocation for each facility shall be determined by dividing the sum of the reported allowable prior period actual depreciation, subject to RCW 74.46.310 through 74.46.380, adjusted for any capitalized additions or replacements approved by the department, and the retained savings from such cost center, by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on eighty-five percent facility occupancy. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property component rate shall be adjusted to anticipated resident day level.

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

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

(4) For the purpose of calculating a nursing facility's property component rate, if a contractor elects to bank licensed beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than eighty-five

percent occupancy of the facility's licensed bed capacity after banking or conversion.

(5) The property component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with ((~~section 18 of this act~~)) RCW 74.46.421. ((~~If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.~~))

NEW SECTION. **Sec. 11.** (1) Beginning July 1, 1999, the department shall establish for each medicaid nursing facility a financing allowance component rate allocation. The financing allowance component rate shall be rebased annually, effective July 1st, in accordance with the provisions of this section and this chapter.

(2) The financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on eighty-five percent facility occupancy. However, assets acquired on or after the effective date of this section shall be grouped in a separate financing allowance calculation that shall be multiplied by .085. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to the effective date of this section. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing allowance shall be adjusted to the greater of the anticipated resident day level or eighty-five percent of the new licensed bed capacity.

(3) In computing the portion of net invested funds representing the net book value of tangible fixed assets, the same assets, depreciation bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,

74.46.360, 74.46.370, and 74.46.380, including owned and leased assets, shall be utilized, except that the capitalized cost of land upon which the facility is located and such other contiguous land which is reasonable and necessary for use in the regular course of providing resident care shall also be included. Subject to provisions and limitations contained in this chapter, for land purchased by owners or lessors before July 18, 1984, capitalized cost of land shall be the buyer's capitalized cost. For all partial or whole rate periods after July 17, 1984, if the land is purchased after July 17, 1984, capitalized cost shall be that of the owner of record on July 17, 1984, or buyer's capitalized cost, whichever is lower. In the case of leased facilities where the net invested funds are unknown or the contractor is unable to provide necessary information to determine net invested funds, the secretary shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to RCW 74.46.360(1).

(4) For the purpose of calculating a nursing facility's financing allowance component rate, if a contractor elects to bank licensed beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion.

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

NEW SECTION. **Sec. 12.** (1) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement, and for which the annualized lease payment, plus any interest and depreciation expenses associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property component rate allocation, is more than the sum of the financing allowance and the variable return rate determined according to this chapter, the following shall apply:

(a) The financing allowance shall be recomputed substituting the fair market value of the assets as of January 1, 1982, as determined by

the department of general administration through an appraisal procedure, less accumulated depreciation on the lessor's assets since January 1, 1982, for the net book value of the assets in determining net invested funds for the facility. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such a determination is shown to be arbitrary and capricious.

(b) The sum of the financing allowance computed under (a) of this subsection and the variable return rate shall be compared to the annualized lease payment, plus any interest and depreciation associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property component rate. The lesser of the two amounts shall be called the alternate return on investment rate.

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

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

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

Sec. 13. RCW 74.46.350 and 1980 c 177 s 35 are each amended to read as follows:

(1) Buildings, land improvements, and fixed equipment shall be depreciated using the straight-line method of depreciation. <u>For new or replacement building construction or for major renovations, either of which receives certificate of need approval or certificate of need exemption under chapter 70.38 RCW on or after the effective date of this section, the number of years used to depreciate fixed equipment shall be the same number of years as the life of the building to which</u>

it is affixed. Major-minor equipment shall be depreciated using either the straight-line method, the sum-of-the-years' digits method, or declining balance method not to exceed one hundred fifty percent of the straight line rate. Contractors who have elected to take either the sum-of-the-years' digits method or the declining balance method of depreciation on major-minor equipment may change to the straight-line method without permission of the department.

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

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

Sec. 14. RCW 74.46.370 and 1997 c 277 s 2 are each amended to read as follows:

(1) Except for new buildings, major remodels, and major repair projects, as defined in subsection (2) of this section, the contractor shall use lives which reflect the estimated actual useful life of the asset and which shall be no shorter than guideline lives as established by the department. Lives shall be measured from the date on which the assets were first used in the medical care program or from the date of the most recent arm's-length acquisition of the asset, whichever is more recent. In cases where RCW 74.46.360(6)(a) does apply, the shortest life that may be used for buildings is the remaining useful life under the prior contract. In all cases, lives shall be extended to reflect periods, if any, when assets were not used in or as a facility.

(2) Effective July 1, 1997, for asset acquisitions and new facilities, major remodels, and major repair projects that begin operations on or after July 1, 1997, the department shall use the most current edition of Estimated Useful Lives of Depreciable Hospital Assets, or as it may be renamed, published by the American Hospital Publishing, Inc., an American hospital association company, for determining the useful life of new buildings, major remodels, and major repair projects, however, the shortest life that may be used for new buildings receiving certificate of need approval or certificate of need exemptions under chapter 70.38 RCW on or after the effective date of this section, is ((~~thirty~~)) forty years. New buildings, major

remodels, and major repair projects include those projects that meet or exceed the expenditure minimum established by the department of health pursuant to chapter 70.38 RCW.

(3) Building improvements, other than major remodels and major repairs, shall be depreciated over the remaining useful life of the building, as modified by the improvement.

(4) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement.

(5) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

(6) For new or replacement building construction or for major renovations, either of which receives certificate of need approval or certificate of need exemption under chapter 70.38 RCW on or after the effective date of this section, the number of years used to depreciate fixed equipment shall be the same number of years as the life of the building to which it is affixed.

NEW SECTION. **Sec. 15.** If a contractor experiences an increase in state or county property taxes as a result of new building construction, replacement building construction, or substantial building additions that require the acquisition of land, then the department shall adjust the contractor's prospective rates to cover the medicaid share of the tax increase. The rate adjustments shall only apply to construction and additions completed on or after July 1, 1997. The rate adjustments authorized by this section are effective on the first day after July 1, 1999, on which the increased tax payment is due. Rate adjustments made under this section are subject to all applicable cost limitations contained in this chapter.

NEW SECTION. **Sec. 16.** Sections 9 through 12 and 15 of this act are each added to part E of chapter 74.46 RCW.

NEW SECTION. **Sec. 17.** The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, 2001:

(1) RCW 74.46.--- and 1999 c . . . s 9 (section 9 of this act);

(2) RCW 74.46.--- and 1999 c . . . s 10 (section 10 of this act) & 1998 c 322 s 29 (uncodified);

(3) RCW 74.46.--- and 1999 c . . . s 11 (section 11 of this act);

(4) RCW 74.46.--- and 1999 c . . . s 12 (section 12 of this act);

(5) RCW 74.46.350 (Methods of depreciation) and 1999 c . . . s 13 (section 13 of this act) & 1980 c 177 s 35;

(6) RCW 74.46.370 (Lives of assets) and 1999 c . . . s 14 (section 14 of this act), 1997 c 277 s 2, & 1980 c 177 s 37; and

(7) RCW 74.46.--- and 1999 c . . . s 15 (section 15 of this act).

NEW SECTION. **Sec. 18.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions. Section 11 of this act takes effect immediately, and sections 1 through 10 and 12 through 17 take effect July 1, 1999."

E2SHB 1484 - S COMM AMD
By Committee on Ways & Means

ADOPTED 4/21/99

On page 1, line 2 of the title, after "facilities;" strike the remainder of the title and insert "amending RCW 74.46.020, 74.46.360, 74.46.421, 74.46.431, 74.46.506, 74.46.511, 74.46.515, 74.46.521, 74.46.350, and 74.46.370; amending 1998 c 322 s 29 (uncodified); adding new sections to chapter 74.46 RCW; repealing RCW 74.46.350 and 74.46.370; repealing 1998 c 322 s 29 (uncodified); providing an effective date; and declaring an emergency."

--- END ---