AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-010 Definitions. Unless the context indicates otherwise, the following definitions apply in this chapter.

"Accounting" means activities providing information, usually quantitative and often expressed in monetary units, for:

(1) Decision making;

(2) Planning;

(3) Evaluating performance;

(4) Controlling resources and operations; and

(5) External financial reporting to investors, creditors, regulatory authorities, and the public.

"Accrual method of accounting" is 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.

"Administration and management" means activities used to maintain, control, and evaluate the efforts and resources of an organization for the accomplishment of the objectives and policies of that organization.

"Allowable costs" are documented costs that are necessary, ordinary, reasonable, and related to the care of medicaid recipients, and are not expressly declared nonallowable by this chapter or chapter 74.46 RCW. Costs are ordinary if they are of the nature and magnitude that prudent and cost conscious management would pay.

((**"Allowable depreciation costs"** are depreciation costs of tangible assets, whether owned or leased by the contractor, meeting the criteria specified in WAC 388-96-552.))

"Assignment of contract" means:

(1) A new nursing facility licensee has elected to care for medicaid residents;

(2) The department finds no good cause to object to continuing the medicaid contract at the facility; and

(3) The new licensee accepts assignment of the immediately preceding contractor's contract at the facility.

"Bad debts" are amounts considered to be uncollectible from accounts and notes receivable.

"Banked beds" are beds removed from service under chapter 246-310 WAC.

"Beneficial owner" is:

(1) Any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares one or more of the following:

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

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

(2) 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 of 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;

(3) 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:

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

(b) Through the conversation of an ownership interest;

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

(d) 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 (3)(a), (b), or (c) 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;

(4) 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:

(a) 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

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

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

(ii) 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.

((~~**"Capitalized lease"** means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.~~))

"Building" means the basic structure or shell of a facility and additions thereto. All allowable sections of a building are enclosed on all sides with a roof and are permanent.

"Capital" means the component of the rate that uses a fair market rental system to set a price per bed.

"Cash method of accounting" means a method of accounting in which revenues are recorded when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for those expenditures and assets.

"Change of ownership" means a substitution, elimination, or withdrawal of the individual operator or operating entity contracting with the department to deliver care services to medical care recipients in a nursing facility and ultimately responsible for the daily operational decisions of the nursing facility.

(1) Events which constitute a change of ownership include, but are not limited to, the following:

(a) Changing the form of legal organization of the contractor, e.g., a sole proprietor forms a partnership or corporation;

(b) Transferring ownership of the nursing facility business enterprise to another party, regardless of whether ownership of some or all of the real property and/or personal property assets of the facility are also transferred;

(c) Dissolving of a partnership;

(d) Dissolving the corporation, merging the corporation with another corporation, which is the survivor, or consolidating with one or more other corporations to form a new corporation;

(e) Transferring, whether by a single transaction or multiple transactions within any continuous twenty-four-month period, fifty percent or more of the stock to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction;

(f) Substituting of the individual operator or the operating entity by any other event or combination of events that results in a substitution or substitution of control of the individual operator or the operating entity contracting with the department to deliver care services; or

(g) A nursing facility ceases to operate.

(2) Ownership does not change when the following, without more, occurs:

(a) A party contracts with the contractor to manage the nursing facility enterprise as the contractor's agent, i.e., subject to the contractor's general approval of daily operating and management decisions; or

(b) The real property or personal property assets of the nursing facility change ownership or are leased, or a lease of them is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity contracting with the department to deliver care services.

"Charity allowance" means a reduction in charges made by the contractor because of the indigence or medical indigence of a patient.

"Component rate allocation(s)" means the initial component rate allocation(s) of the rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "component rate allocation(s)," it means the initial component rate allocation(s) of the rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Contract" means an agreement between the department and a contractor for the delivery of nursing facility services to medical care recipients.

"Cost report" means all schedules of a nursing facility's cost report submitted according to the department's instructions.

"Courtesy allowances" are reductions in charges in the form of an allowance to physicians, clergy, and others, for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

"Department" means department of social and health services and its employees.

"Direct care supplies (DCS)" are those supplies:

(1) Used by staff providing direct care to residents;

(2) Consumed during a single accounting period; and

(3) Expensed in that accounting period. Supplies excluded from DCS include but are not limited to the following:

(1) medical equipment (such as IV poles);

(2) Items covered by medicaid fee-for-service system; and

(3) Administrative supplies used by direct care staff (such as pencils, pens, paper, office supplies, etc).

"Donated asset" means an asset the contractor acquired without making any payment for the asset either in cash, property, or services. An asset is not a donated asset if the contractor:

(1) Made even a nominal payment in acquiring the asset; or

(2) Used donated funds to purchase the asset.

((~~**"Essential community provider"** means a facility that is the only nursing facility within a commuting distance radius of at least forty minutes duration, traveling by automobile.~~))

"Equity capital" means total tangible and other assets which are necessary, ordinary, and related to patient care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital defined as current assets minus current liabilities.

"Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods. As determined by context or otherwise, **"fiscal year"** may also refer to a state fiscal year extending from July 1 through June 30 of the following year and comprising the first or second half of a state fiscal biennium.

"Fixed equipment" means attachments to buildings including, but not limited to, wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. Generally, fixed equipment is affixed to the building and not subject to transer.

"Gain on sale" means the actual total sales price of all tangible and intangible nursing facility assets including, but not limited to, land, building, equipment, supplies, goodwill, and beds authorized by certificate of need, minus the net book value of such assets immediately prior to the time of sale.

"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.

"Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

"Intangible asset" is an asset that lacks physical substance but possesses economic value.

"Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

"Joint facility costs" are any costs that benefit more than one facility, or one facility and any other entity.

((~~**"Large nonessential community providers"** are not essential community providers and have more than sixty licensed beds regardless of how many beds are set up or in use. Licensed beds include any beds banked under chapter 70.38 RCW.~~))

"Leasehold improvements" are betterments and additions made by the lessee to the leased property that become the property of the lessor after the expiration of the lease.

"Movable equipment" includes, but is not limited to, beds, wheelchairs, desks, and X-ray machines. The general characteristics of movable equipment are:

(1) Capable of being moved as distinguished from fixed equipment;

(2) A unit cost sufficient to justify ledger control;

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

(4) A minimum life of greater than one year.

"Multiservice facility" means a facility at which two or more types of health or related care are delivered, e.g., a hospital and nursing facility, or a boarding home and nursing facility.

"Nonadministrative wages and benefits" are wages, benefits, and corresponding payroll taxes paid for nonadministrative personnel, not to include administrator, assistant administrator, or administrator-in-training.

"Nonallowable costs" are the same as **"unallowable costs."**

"Nonrestricted funds" are funds that are not restricted to a specific use by the donor, e.g., general operating funds.

"Nursing facility occupancy percentage" is a percentage determined by multiplying the number of calendar days for the cost report period by the number of licensed beds, regardless of how many beds are set up, in use, or banked under chapter 70.38 RCW, for the same cost report period. Then, the product is divided into the nursing facility's actual resident days for the same cost report period.

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

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

"Per diem (per patient day or per resident day) costs" means total allowable costs for a fiscal period divided by total patient or resident days for the same period.

"Prospective daily payment rate" means the rate assigned by the department to a contractor for providing service to medical care recipients prior to the application of settlement principles.

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

"Recipient" means a medicaid recipient.

"Related care" means only those services that are directly related to providing direct care to nursing facility residents including but not limited to:

(1) The director of nursing services;

(2) Nursing direction and supervision;

(3) Activities and social services programs;

(4) Medical and medical records specialists.

(5) Consultation provided by:

(a) Medical directors; and

(b) Pharmacists.

"Relative" includes:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted child((~~, or~~)), adoptive parent, or adoptive sibling;

(4) Stepparent, stepchild, stepbrother, stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law;

(6) Grandparent or grandchild; and

(7) Uncle, aunt, nephew, niece, or cousin.

"Related organization" means an entity that 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 or person is the beneficial owner of five percent or more ownership interest in the contractor and any other entity.

(b) "Control" exists where an entity or person 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 and exercised.

"Renovations" means the cost of the building, building improvements, leasehold improvements, and fixed equipment used to calculate a facility's age. In order to be used to calculate a facility's age, the cost of renovations in a calendar year must be $2,000 or greater per licensed bed.

"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.

((~~**"Small nonessential community providers"** are not essential community providers and have sixty or fewer licensed beds regardless of how many beds are set up or in use. Licensed beds include any beds banked under chapter 70.38 RCW.~~))

"Start up costs" are the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first patient is admitted. Start up costs include:

(1) Administrative and nursing salaries;
(2) Utility costs;
(3) Taxes;
(4) Insurance;
(5) Repairs and maintenance; and
(6) Training costs.

Start up costs do not include expenditures for capital assets.

"Total rate allocation" means the initial rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "total rate allocation," it means the initial rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Unallowable costs" are costs that do not meet every test of an allowable cost.

"Uniform chart of accounts" are account titles identified by code numbers established by the department for contractors to use in reporting costs.

"Vendor number" means a number assigned to each contractor delivering care services to medical care recipients.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-022 Due dates for cost reports. (1) The contractor ((~~shall~~)) must submit annually a complete report of costs and financial conditions of the contractor prepared and presented in a standardized manner and in accordance with this chapter and chapter 74.46 RCW.

(2) The department will review the contractor's costs and financial conditions in accordance with the methodology effective at the time the contractor incurred the costs.

(3) Not later than March 31st of each year, each contractor ((~~shall~~)) must submit to the department an annual cost report for the period from January 1st through December 31st of the preceding year.

((~~(3)~~)) (4) Not later than one hundred twenty days following the termination or assignment of a contract, the terminating or assigning contractor ((~~shall~~)) must submit to the department a cost report for the period from January 1st through the date the contract was terminated or assigned.

((~~(4)~~)) (5) If the cost report is not properly completed or if it is not received by the due date established in subsection ((~~(2)~~)) (3) or ((~~(3)~~)) (4) of this section, all or part of any payments due under the contract may be withheld by the department until such time as required cost report is properly completed and received.

((~~(5)~~)) (6) The department may impose civil fines, or take adverse rate action against contractors and former contractors who do not submit properly completed cost reports by the applicable due date established in subsection ((~~(2)~~)) (3) or ((~~(3)~~)) (4) of this section.

AMENDATORY SECTION (Amending WSR 89-01-095, filed 12/21/88)

WAC 388-96-107 Requests for extensions. (1) A contractor may request in writing an extension for submitting cost reports. Contractor requests ((~~shall~~)) must:

(a) Be addressed to the manager, ((~~residential~~)) nursing facility rates program;

(b) State the circumstances prohibiting compliance with the report due date; and

(c) Be received by the department at least ten days prior to the due date of the report.

(2) The department may grant two extensions of up to thirty days each, only if the circumstances, stated clearly, indicate the due date cannot be met and the following conditions are present:

(a) The circumstances were not foreseeable by the provider; and

(b) The circumstances were not avoidable by advance planning.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-205 Purposes of department audits—Examination—Incomplete or incorrect reports—Contractor's duties—Access to facility—Fines—Adverse rate actions. (1) The purposes of department audits and examinations under this chapter and chapter 74.46 RCW are to ascertain that:

(a) Allowable costs for each year for each medicaid nursing facility are accurately reported;

(b) Cost reports accurately reflect the true financial condition, revenues, expenditures, equity, beneficial ownership, related party status, and records of the contractor;

(c) The contractor's revenues, expenditures, ((~~and costs of the building, land, land improvements, building improvements, and movable~~

~~and fixed equipment~~)) building square footage, building improvements, leasehold improvements, fixed equipment, and age are recorded in compliance with department requirements, instructions, and generally accepted accounting principles;

(d) The contractor is in compliance with the direct care staffing requirements found in this chapter and in chapter 74.42 RCW;

(e) The responsibility of the contractor has been met in the maintenance and disbursement of patient trust funds; and

((~~(e)~~)) (f) The contractor has reported and maintained accounts receivable in compliance with this chapter and chapter 74.46 RCW.

(2) The department ((~~shall~~)) must examine the submitted cost report, or a portion thereof, of each contractor for each nursing facility for each report period to determine whether the information is correct, complete, reported in conformance with department instructions and generally accepted accounting principles, the requirements of this chapter, and chapter 74.46 RCW. The department ((~~shall~~)) must determine the scope of the examination.

(3) When the department finds that the cost report is incorrect or incomplete, the department may make adjustments to the reported information for purposes of establishing component rate allocations or in determining amounts to be recovered in direct care((~~, therapy care, and support services~~)) under WAC 388-96-211 (3) and (4) or in any component rate resulting from undocumented or misreported costs. A schedule of the adjustments ((~~shall~~)) must be provided to the contractor, including dollar amount and explanations for the adjustments. Adjustments ((~~shall be~~)) are subject to review under WAC 388-96-901 and 388-96-904.

(4) Audits of resident trust funds and receivables ((~~shall~~)) must be reported separately and in accordance with the provisions of this chapter and chapter 74.46 RCW.

(5) The contractor ((~~shall~~)) must:

(a) Provide access to the nursing facility, all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds. To ensure accuracy, the department may require the contractor to submit for departmental review any underlying financial statements or other records, including income tax returns, relating to the cost report directly or indirectly;

(b) ((~~Prepare a reconciliation of the cost report with:~~

~~(i) Applicable federal income and federal and state payroll tax returns; and~~

~~(ii) The records for the period covered by the cost report.~~

~~(c)~~)) Make available to the department staff an individual or individuals to respond to questions and requests for information from department staff. The designated individual or individuals ((~~shall~~)) must have sufficient knowledge of the issues, operations, or functions to provide accurate and reliable information; and

(c) Prepare a reconciliation of the cost report with:

(i) Applicable federal income and federal and state payroll tax returns; and

(ii) The records for the period covered by the cost report.

(6) If an examination discloses material discrepancies, undocumented costs, or mishandling of resident trust funds, the department may open or reopen one or both of the two preceding cost report or resident trust fund periods, whether examined or unexamined, for indication of similar discrepancies, undocumented costs, or mishandling of resident trust funds.

(7) Any assets, liabilities, revenues, or expenses reported as allowable that are not supported by adequate documentation in the contractor's records ((~~shall~~)) must be disallowed. Documentation must show both that costs reported were incurred during the period covered by the report and were related to resident care, and that assets reported were used in the provision of resident care.

(8) When access is required at the facility or at another location in the state, the department ((~~shall~~)) must notify a contractor of its intent to examine all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds.

(9) The department is authorized to assess civil fines and take adverse rate action if a contractor, or any of its employees, does not allow access to the contractor's nursing facility records.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-208 Reconciliation of medicaid resident days to billed days and medicaid payments—Payments due—Accrued interest—Withholding funds. (1) The methodology in subsections (2) through (6) of this section is effective for services provided on or before June 30, 2016.

(2) The department ((~~shall~~)) must reconcile medicaid resident days to billed days and medicaid payments for each medicaid nursing facility for each calendar year, or for that portion of the calendar year the provider's contract was in effect.

((~~(2)~~)) (3) The contractor ((~~shall~~)) must make any payment owed the department as determined by reconciliation and/or settlement at the lower of cost or rate in direct care, therapy care, and support services component rate allocations within sixty days after the department notifies the contractor of the amount owed.

((~~(3)~~)) (4) The department ((~~shall~~)) must pay the contractor within sixty days after it notifies the contractor of an underpayment.

((~~(4)~~)) (5) Interest at the rate of one percent per month accrues against the department or the contractor on an unpaid balance existing sixty days after notification of the contractor. Accrued interest ((~~shall~~)) must be adjusted back to the date it began to accrue if the payment obligation is subsequently revised after administrative or judicial review.

((~~(5)~~)) (6) The department ((~~shall~~)) may withhold funds from the contractor's payment for services and ((~~shall~~)) may take all other actions authorized by law to recover from the contractor amounts due and payable including any accrued interest. Neither a timely filed appeal under WAC 388-96-901 and 388-96-904 nor the commencement of judicial review as may be available to the contractor in law to contest a payment obligation determination shall delay recovery from the contractor or payment to the contractor.

(7) The methodology in subsections (8) through (12) of this section is effective for services provided on or after July 1, 2016.

(8) The department must reconcile medicaid resident days to billed days and medicaid payments for each medicaid nursing facility for

each calendar year, or for that portion of the calendar year the provider's contract was in effect.

(9) The contractor must make any payment owed the department as determined by either reconciliation, settlement, or both at the lower of cost or rate in the direct care component rate allocation within sixty days after the department notifies the contractor of the amount owed.

(10) The department must pay the contractor within sixty days after it notifies the contractor of an underpayment.

(11) Interest at the rate of one percent per month accrues against the department or the contractor on an unpaid balance existing sixty days after notification of the contractor. Accrued interest must be adjusted back to the date it began to accrue if the payment obligation is subsequently revised after administrative or judicial review.

(12) The department may withhold funds from the contractor's payment for services and may take all other actions authorized by law to recover from the contractor amounts due and payable including any accrued interest. Neither a timely filed appeal under WAC 388-96-901 and 388-96-904 nor the commencement of judicial review as may be available to the contractor in law to contest a payment obligation determination must delay recovery from the contractor or payment to the contractor.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-211 Proposed settlement report—Payment refunds—Overpayments—Determination of unused rate funds—Total and component payment rates. (1) The methodology in subsections (2) through (6) of this section is effective for services provided on or before June 30, 2016.

(2) Contractors ((~~shall~~)) must submit with each annual nursing facility cost report a proposed settlement report showing underspending or overspending in each component rate during the cost report year on a per-resident day basis. The department ((~~shall~~)) must accept or reject the proposed settlement report, explain any adjustments, and if needed, issue a revised settlement report.

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

((~~(3)~~)) (4) The facility will return to the department any overpayment amounts in each of the direct care, therapy care, and support services rate components that the department identifies following the examination and settlement procedures as described in this chapter, provided that the contractor may retain any overpayment that does not exceed one percent of the facility's direct care, therapy care, and support services component rate. However, no overpayments may be retained in a cost center to which savings have been shifted to cover a deficit, as provided in subsection ((~~(4)~~)) (5) of this section. Facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's

direct care, therapy care, and support services component rate. The terms "not in substantial compliance" and "substandard quality of care" ((~~shall~~)) must be defined by federal survey regulations.

((~~(4)~~)) (5) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, ((~~shall~~)) must be done separately for each rate component, and, except as otherwise provided in this subsection, neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any. In computing a preliminary or final settlement, savings in the support services cost center ((~~shall~~)) must be shifted to cover a deficit in the direct care or therapy cost centers up to the amount of any savings, but no more than twenty percent of the support services component rate may be shifted. In computing a preliminary or final settlement, savings in direct care and therapy care may be shifted to cover a deficit in these two cost centers up to the amount of savings in each, regardless of the percentage of either component rate shifted. Contractor-retained overpayments up to one percent of direct care, therapy care, and support services rate components, as authorized in subsection ((~~(3)~~)) (4) of this section, ((~~shall~~)) must be calculated and applied after all shifting is completed.

((~~(5)~~)) (6) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and chapter 74.46 RCW ((~~shall~~)) represent the maximum payment for nursing facility services rendered to medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

(7) The methodology in subsections (8) through (11) of this section is effective for services provided on or after July 1, 2016.

(8) Contractors must submit with each annual nursing facility cost report a proposed settlement report showing underspending or overspending in each component rate during the cost report year on a per-resident day basis. The department must accept or reject the proposed settlement report, explain any adjustments, and if needed, issue a revised settlement report.

(9) Contractors are not required to refund payments made in the indirect care, capital, and quality enhancement component rates in excess of the adjusted costs of providing services corresponding to these components.

(10) The facility will return to the department any overpayment amounts in the direct care rate component that the department identifies following the examination and settlement procedures as described in this chapter. The contractor may retain any overpayment that does not exceed one percent of the facility's direct care component rate, however facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care component rate. The terms "not in substantial compliance" and "substandard quality of care" must be defined by federal survey regulations.

(11) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and chapter 74.46 RCW represent the maximum payment for nursing facility services rendered to medicaid recipients for the pe-

riod the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-218 Proposed, preliminary, and final settlements. (1) The methodology in subsections (2) through (14) of this section is effective for services provided on or before June 30, 2016.

(2) For each component rate, the department ((~~shall~~)) must calculate a proposed, preliminary or final settlement at the lower of prospective payment rate or audited allowable costs, except as otherwise provided in this chapter and chapter 74.46 RCW.

((~~(2)~~)) (3) As part of the cost report, the proposed settlement report is due in accordance with WAC 388-96-022. In the proposed preliminary settlement report, a contractor ((~~shall~~)) must compare the contractor's payment rates during a cost report period, weighted by the number of resident days reported for the same cost report period to the contractor's allowable costs for the cost report period. In accordance with WAC 388-96-205, 388-96-208 and 388-96-211 the contractor ((~~shall~~)) must take into account all authorized shifting, retained savings, and upper limits to rates on a cost center basis.

((~~(a)~~)) (4) The department will((~~:~~

~~(i)~~)) review the proposed preliminary settlement report for accuracy((~~;~~)) and

((~~(ii)~~)) accept or reject the ((~~proposal of the~~)) contractor's proposal. If accepted, the proposed preliminary settlement report ((~~shall~~)) must become the preliminary settlement report. If rejected, the department ((~~shall~~)) must issue, by component payment rate allocation, a preliminary settlement report fully substantiating disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

((~~(b)~~)) (5) When the department receives the proposed preliminary settlement report((~~:~~

~~(i)~~)) by the cost report due date specified in WAC 388-96-022, it will issue the preliminary settlement report within one hundred twenty days of the cost report due date((~~; or~~

~~(ii) A~~)) When the department receives the proposed preliminary settlement report after the cost report due date specified in WAC 388-96-022, it will issue the preliminary settlement report within one hundred twenty days of the date the cost report was received.

((~~(c)~~)) In its discretion, the department may designate a date later than the dates specified in this subsection ((~~(2)(b)(i) and (ii) of this section~~)) to issue preliminary settlements.

((~~(d)~~)) (6) A contractor shall have twenty-eight days after receipt of a preliminary settlement report to contest such report under WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight day period, the department ((~~shall~~)) must not review or adjust a preliminary settlement report. Any administrative review of a preliminary settlement ((~~shall~~)) must be limited to calculation of the settlement, to the application of settlement principles and rules, or both, and ((~~shall~~)) must not encompass rate or audit issues.

((~~(3)~~)) (7) The department ((~~shall~~)) must issue a final settlement report to the contractor after the completion of the department audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

((~~(a)~~)) (8) The department ((~~shall~~)) must prepare a final settlement by component payment rate allocation and ((~~shall~~)) must fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department ((~~shall~~)) must take into account all authorized shifting, savings, and upper limits to rates on a component payment rate allocation basis. For the final settlement report, the department ((~~shall~~)) must compare:

((~~(i)~~)) (a) The payment rates it paid the contractor for the facility in question during the report period, weighted by the number of allowable resident days reported for the period each rate was in effect to the contractor's;

((~~(ii)~~)) (b) Audited allowable costs for the reporting period; or

((~~(iii)~~)) (c) Reported costs for the nonaudited reporting period.

((~~(b)~~)) (9) A contractor ((~~shall have~~)) has twenty-eight days after the receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight day period, the department ((~~shall~~)) must not review a final settlement report. Any administrative review of a final settlement ((~~shall~~)) must be limited to calculation of the settlement, the application of settlement principles and rules, or both, and ((~~shall~~)) must not encompass rate or audit issues.

((~~(c)~~)) (10) The department ((~~shall~~)) may reopen a final settlement if it is necessary to make adjustments based upon findings resulting from a department audit performed pursuant to WAC 388-96-205. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's medicaid recipient days.

((~~(4)(a)~~)) (11) In computing a preliminary or final settlement, a contractor must comply with the requirements of WAC 388-96-211 for retaining or refunding to the department payments made in excess of the adjusted costs of providing services corresponding to each component rate allocation.

((~~(b)~~)) (12) The nursing facility contractor ((~~shall~~)) must refund all amounts due the department within sixty days after the department notifies the contractor of the overpayment and demands repayment. When notification is by postal mail, the department ((~~shall~~)) must deem the contractor to have received the department's notice five calendar days after the date of the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt ((~~shall~~)) must be used to determine the sixty day period for repayment. After the sixty day period, interest on any unpaid balance will accrue at one percent per month.

((~~(c)~~)) (13) Repayment will be without prejudice to obtain review of the settlement determination pursuant to WAC 388-96-901 and 388-96-904. After an administrative hearing and/or judicial review, if the payment obligation is reduced, then the department will rescind the difference between the accrued interest on the payment obligation and the interest that would have accrued on the reduced payment obli-

gation from the date interest began to accrue on the original payment obligation.

((~~(5)~~)) (14) In determining whether a facility has forfeited unused rate funds in its direct care, therapy care and support services component rates under authority of WAC 388-96-211, the following rules ((~~shall~~)) apply:

(a) Federal or state survey officials ((~~shall~~)) must determine when a facility is not in substantial compliance or is providing substandard care, according to federal and state nursing facility survey regulations;

(b) Correspondence from state or federal survey officials notifying a facility of its compliance status ((~~shall~~)) must be used to determine the beginning and ending dates of any period(s) of noncompliance; and

(c) Forfeiture ((~~shall~~)) must occur if the facility was out of substantial compliance more than ninety days during the settlement period. The ninety-day period need not be continuous if the number of days of noncompliance exceed ninety days during the settlement period regardless of the length of the settlement period. Also, forfeiture ((~~shall~~)) must occur if the nursing facility was determined to have provided substandard quality of care at any time during the settlement period.

(15) The methodology in subsections (16) through (28) of this section is effective for services provided on or after July 1, 2016.

(16) For each component rate, the department must calculate a proposed, preliminary or final settlement at the lower of prospective payment rate or audited allowable costs, except as otherwise provided in this chapter and chapter 74.46 RCW.

(17) As part of the cost report, the proposed settlement report is due in accordance with WAC 388-96-022. In the proposed preliminary settlement report, a contractor must compare the contractor's payment rates during a cost report period, weighted by the number of resident days reported for the same cost report period to the contractor's allowable costs for the cost report period. In accordance with WAC 388-96-205, 388-96-208 and 388-96-211 the contractor must take into account all retained savings, and upper limits to rates on a cost center basis.

(18) The department will review the proposed preliminary settlement report for accuracy and accept or reject the contractor's proposal. If accepted, the proposed preliminary settlement report must become the preliminary settlement report. If rejected, the department must issue, by component payment rate allocation, a preliminary settlement report fully substantiating disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(19) When the department receives the proposed preliminary settlement report by the cost report due date specified in WAC 388-96-022, it will issue the preliminary settlement report within one hundred twenty days of the cost report due date. When the department receives the proposed preliminary settlement report after the cost report due date specified in WAC 388-96-022, it will issue the preliminary settlement report within one hundred twenty days of the date the cost report was received. In its discretion, the department may designate a date later than the dates specified in this subsection to issue preliminary settlements.

(20) A contractor has twenty-eight days after receipt of a preliminary settlement report to contest such report under WAC 388-96-901

and 388-96-904. Upon expiration of the twenty-eight day period, the department must not review or adjust a preliminary settlement report. Any administrative review of a preliminary settlement must be limited to calculation of the settlement, to the application of settlement principles and rules, or both, and must not encompass rate or audit issues.

(21) The department must issue a final settlement report to the contractor after the completion of the department audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

(22) The department must prepare a final settlement by component payment rate allocation and must fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department must take into account all authorized shifting, savings, and upper limits to rates on a component payment rate allocation basis. For the final settlement report, the department must compare:

(a) The payment rates it paid the contractor for the facility in question during the report period, weighted by the number of allowable resident days reported for the period each rate was in effect to the contractor's;

(b) Audited allowable costs for the reporting period; or

(c) Reported costs for the nonaudited reporting period.

(23) A contractor has twenty-eight days after the receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight day period, the department must not review a final settlement report. Any administrative review of a final settlement must be limited to calculation of the settlement, the application of settlement principles and rules, or both, and must not encompass rate or audit issues.

(24) The department may reopen a final settlement if it is necessary to make adjustments based upon findings resulting from a department audit performed pursuant to WAC 388-96-205. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's medicaid recipient days.

(25) In computing a preliminary or final settlement, a contractor must comply with the requirements of WAC 388-96-211 for retaining or refunding to the department payments made in excess of the adjusted costs of providing services corresponding to each component rate allocation.

(26) The nursing facility contractor must refund all amounts due the department within sixty days after the department notifies the contractor of the overpayment and demands repayment. When notification is by postal mail, the department must deem the contractor to have received the department's notice five calendar days after the date of the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt must be used to determine the sixty day period for repayment. After the sixty day period, interest on any unpaid balance will accrue at one percent per month.

(27) Repayment will be without prejudice to obtain review of the settlement determination pursuant to WAC 388-96-901 and 388-96-904. After an administrative hearing and/or judicial review, if the payment obligation is reduced, then the department will rescind the difference

between the accrued interest on the payment obligation and the interest that would have accrued on the reduced payment obligation from the date interest began to accrue on the original payment obligation.

(28) In determining whether a facility has forfeited unused rate funds in its direct care component rate under authority of WAC 388-96-211, the following rules apply:

(a) Federal or state survey officials must determine when a facility is not in substantial compliance or is providing substandard care, according to federal and state nursing facility survey regulations;

(b) Correspondence from state or federal survey officials notifying a facility of its compliance status must be used to determine the beginning and ending dates of any period(s) of noncompliance; and

(c) Forfeiture must occur if the facility was out of substantial compliance more than ninety days during the settlement period. The ninety-day period need not be continuous if the number of days of noncompliance exceed ninety days during the settlement period regardless of the length of the settlement period. Also, forfeiture must occur if the nursing facility was determined to have provided substandard quality of care at any time during the settlement period.

AMENDATORY SECTION (Amending WSR 98-20-023, filed 9/25/98, effective 10/1/98)

WAC 388-96-505 Offset of miscellaneous revenues. (1) The methodology in subsections (2) through (5) of this section is effective for services provided on or before June 30, 2016.

(2) The contractor ((~~shall~~)) must reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts, refunds of allowable costs or rebates) other than through the contractor's normal billing for care services; except, the department ((~~shall~~)) must not deduct from the allowable costs of a nonprofit facility unrestricted grants, gifts, and endowments, and interest therefrom.

((~~(2)~~)) (3) The contractor ((~~shall~~)) must reduce allowable costs for hold-bed revenue in the support services, operations and property rate components only. In the support services rate component, the amount of reduction ((~~shall~~)) must be determined by dividing a facility's allowable housekeeping costs by total adjusted patient days and multiplying the result by total hold-room days. In the operations rate component, the amount of the reduction shall be determined by dividing a facility's allowable operation costs by total adjusted patient days and multiplying the result by total hold-room days. In the property rate component, the amount of reduction ((~~shall~~)) must be determined by dividing allowable property costs by the total adjusted patient days and multiplying the result by total hold-room days.

((~~(3)~~)) (4) Where goods or services are sold, the amount of the reduction ((~~shall be~~)) is the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost, it ((~~shall be~~)) is the full amount of the revenue received. Where financial benefits such as purchase discounts, refunds of allowable costs or rebates are received, the amount of the reduction ((~~shall be~~)) is the amount of the discount or rebate. Financial benefits such as purchase discounts, refunds of allowable costs and rebates, including in-

dustrial insurance rebates, ((~~shall~~)) must be offset against allowable costs in the year the contractor actually receives the benefits.

((~~(4)~~)) (5) Only allowable costs ((~~shall~~)) may be recovered under this section. Costs allocable to activities or services not included in nursing facility services, e.g., costs of vending machines and services specified in chapter 388-86 WAC not included in nursing facility services, are nonallowable costs.

(6) The methodology in subsections (7) through (10) of this section is effective for services provided on or after July 1, 2016.

(7) The contractor must reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts, refunds of allowable costs or rebates) other than through the contractor's normal billing for care services; except, the department must not deduct from the allowable costs of a nonprofit facility unrestricted grants, gifts, and endowments, and interest therefrom.

(8) The contractor must reduce allowable costs for hold-bed revenue in the indirect care rate component only. The amount of reduction must be determined by dividing a facility's allowable housekeeping costs by total adjusted patient days and multiplying the result by total hold-room days.

(9) Where goods or services are sold, the amount of the reduction is the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost, it is the full amount of the revenue received. Where financial benefits such as purchase discounts, refunds of allowable costs or rebates are received, the amount of the reduction is the amount of the discount or rebate. Financial benefits such as purchase discounts, refunds of allowable costs and rebates, including industrial insurance rebates, must be offset against allowable costs in the year the contractor actually receives the benefits.

(10) Only allowable costs may be recovered under this section. Costs allocable to activities or services not included in nursing facility services, e.g., costs of vending machines and services specified in chapter 388-86 WAC not included in nursing facility services, are nonallowable costs.

AMENDATORY SECTION (Amending WSR 98-20-023, filed 9/25/98, effective 10/1/98)

WAC 388-96-525 Education and training. (1) Necessary and ordinary expenses of on-the-job training and in-service training required for employee orientation and certification training directly related to the performance of duties assigned will be allowable costs. Cost of training for which the nursing facility is reimbursed outside the payment rate is an unallowable cost.

(2) Necessary and ordinary expenses of recreational and social activity training conducted by the contractor for volunteers will be allowable costs. Expenses of training programs for other nonemployees will not be allowable costs.

(3) Expenses for travel, lodging, and meals associated with education and training ((~~in the states of Idaho, Oregon, and Washington and the province of British Columbia~~)) are allowable if the expenses meet the requirements of this chapter.

(4) ((~~Except travel, lodging, and meal expenses, education and training expenses at sites outside of the states of Idaho, Oregon, and Washington and the province of British Columbia are allowable costs if the expenses meet the requirements of this chapter.~~

~~(5)~~)) Costs designated by this section as allowable ((~~shall be~~)) are subject to any applicable cost center limit established by this chapter.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-534 Joint cost allocation disclosure (JCAD). (1) The contractor ((~~shall~~)) must disclose to the department:

(a) The nature and purpose of all costs representing allocations of joint facility costs; and

(b) The methodology of the allocation utilized.

(2) The contractor ((~~shall~~)) must demonstrate in such disclosure:

(a) The services involved are necessary and nonduplicative; and

(b) Costs are allocated in accordance with benefits received from the resources represented by those costs.

(3) ((~~The contractor shall make such disclosure not later than September 30th for the following year; except,~~)) Upon receipt of a disclosure, the department must review the joint cost allocation disclosure (JCAD) and either approve or deny the disclosure. Once a JCAD is submitted and approvied, it is valid unil changed or amended.

(4) A new contractor ((~~shall~~)) must submit the first year's disclosure together with the submissions required by WAC 388-96-026.

(5) Within this section, the meaning of the:

(a) "Effective date" is the date the department will recognize allocation per an approved JCAD; and

(b) "Implementation date" is the date the facility will begin or began incurring joint facility costs or the allocation of joint costs has changed.

((~~(4) The department shall approve or reject the JCAD not later than December 31 of each year for all JCADs received by September 30th. The effective date of an approved JCAD received:~~

~~(a) By September 30th is January 1st.~~

~~(b) After September 30th shall be ninety days from the date the JCAD was received by the department.~~

~~(5)~~)) (6) The contractor ((~~shall~~)) must submit to the department for approval an amendment or revision to an approved JCAD at least thirty days prior to the implementation date of the amendment or revision. For amendments or revisions received less than thirty days before the implementation date, the effective date of approval will be thirty days from the date the JCAD is received by the department.

((~~(6)~~)) (7) When a contractor, who is not currently incurring joint facility costs, begins to incur joint facility costs during the calendar year, the contractor ((~~shall~~)) must provide the information required in subsections (1) and (2) of this section at least ninety days prior to the implementation date. If the JCAD is not received ninety days before the implementation date, the effective date of the approval will be ninety days from the date the JCAD is received by the department.

((~~(7)~~)) (8) Joint facility costs not disclosed, allocated, and reported in conformity with this section are unallowable costs. Joint facility costs incurred before the effective dates ((~~of subsections (4), (5), and (6) of this section~~)) are unallowable. Costs disclosed, allocated, and reported in conformity with a department-approved JCAD must undergo review and be determined allowable costs for the purposes of rate setting and audit.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-542 Home office or central office. (1) ((~~When calculating the median lid on home and central office costs and determining which home and central office costs to test against the median lid,~~)) The department will include all allowable, reported home/central office costs including all costs that are ((~~nonduplicative,~~)) documented, ordinary, reasonable, necessary, and related to the provision of medical and personal care services to authorized patients.

(2)((~~(a)~~)) Assets used in the provision of services by or to a nursing facility, but not located on the premises of the nursing facility, ((~~shall~~)) must not be included in ((~~net invested funds or in~~)) the calculation of ((~~property payment~~)) the capital component for the nursing facility except as permissible under WAC 388-96-915.

((~~(b)~~)) (3) The nursing facility may allocate depreciation, interest expense, and operating lease expense for the home office, central office, and other off-premises assets to the cost of the services provided to or by the nursing facility on a reasonable statistical basis approved by the department.

((~~(c)~~)) (4) The allocated costs ((~~of (b) of this~~)) in subsection (3) of this section may be included in the cost of services in such cost centers where such services and related costs are appropriately reported.

((~~(3)~~)) (5) Home office or central office costs must be allocated and reported in conformity with the department-approved JCAD methodology as required by WAC 388-96-534.

((~~(4) Home office or central office costs are subject to the limitation specified in WAC 388-96-585.~~))

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-556 Initial cost of operation. (1) The necessary((~~ and~~)), ordinary, and reasonable one-time expenses directly incident to the preparation of a newly constructed or purchased building by a contractor for operation as a licensed facility ((~~shall be~~)) are allowable costs. These expenses ((~~shall be~~)) are limited to start-up and organizational costs incurred prior to the admission of the first patient.

(2) Start-up costs ((~~shall~~)) include, but ((~~not be~~)) are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, and training((~~; except, that they~~

~~shall exclude~~)). Start-up costs do not include expenditures for capital assets. ((~~These~~)) Start-up costs ((~~will be~~)) are allowable in the ((~~operations~~)) indirect care cost center if they are amortized over a period of not less than sixty months beginning with the month in which the first patient is admitted for care.

(3) Organizational costs are those necessary, ordinary, and directly incident to the creation of a corporation or other form of business of the contractor including, but not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation; except, that they do not include costs relating to the issuance and sale of shares of capital stock or other securities. Such organizational costs will be allowable in the ((~~operations~~)) indirect care cost center if they are amortized over a period of not less than sixty months beginning with the month in which the first patient is admitted for care.

((~~(4) Interest expense and loan origination fees relating to construction of a facility incurred during the period of construction shall be capitalized and amortized over the life of the facility pursuant to WAC 388-96-559. The period of construction shall extend from the date of the construction loan to the date the facility is put into service for patient care and shall not exceed the project certificate of need time period pursuant to RCW 70.38.125.~~))

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-560 Land, improvements((~~—Depreciation.~~ ~~Land is not depreciable. The cost of~~)) Land includes but is not limited to, offsite sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading((~~ of a nondepreciable nature~~)), and the cost of curbs and sidewalks, replacement of which is not the responsibility of the contractor.

AMENDATORY SECTION (Amending WSR 98-20-023, filed 9/25/98, effective 10/1/98)

WAC 388-96-580 Operating leases of office equipment. (1) Rental costs of office equipment under arm's-length operating leases ((~~shall be~~)) are allowable to the extent such costs are necessary, ordinary, and related to patient care.

(2) The department ((~~shall~~)) must pay office equipment rental costs in the ((~~operations~~)) indirect component rate allocation. Office equipment may include items typically used in administrative or clerical functions such as telephones, copy machines, desks and chairs, calculators and adding machines, file cabinets, typewriters, and computers.

((~~(3) The department shall not pay for depreciation of leased office equipment.~~))

AMENDATORY SECTION (Amending WSR 15-09-025, filed 4/7/15, effective 5/8/15)

WAC 388-96-585 Unallowable costs. (1) Unallowable costs listed in subsection (2) of this section represent a partial summary of such costs, in addition to those unallowable under chapter 74.46 RCW and this chapter.

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

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

(b) Costs of services and items provided to recipients which are covered by the medical care program but not included in the medicaid per-resident day payment rate established under this chapter and chapter 74.46 RCW;

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

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

(e) Interest costs other than those provided by WAC 388-96-556(4) on and after January 1, 1985;

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

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

(h) Costs resulting from transactions or the application of accounting methods which circumvent the principles of the payment system set forth in this chapter and chapter 74.46 RCW;

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

(j) Bad debts of non-Title XIX recipients. Bad debts of Title XIX recipients are allowable only when:

(i) The debt is related to covered services;

(ii) It arises from the recipient's required contribution toward the cost of care;

(iii) The provider can establish reasonable collection efforts were made. Reasonable collection efforts ((~~shall~~)) consist of at least three documented attempts by the contractor to obtain payment demonstrating that the effort devoted to collecting the bad debts of Title XIX recipients is the same devoted by the contractor to collect the bad debts of non-Title XIX recipients;

(iv) The debt was actually uncollectible when claimed as worthless; and

(v) Sound business judgment established there was no likelihood of recovery at any time in the future((~~.~~));

(k) Charity and courtesy allowances;

(l) Cash, assessments, or other contributions((~~, excluding dues,~~)) to charitable organizations, professional organizations, trade associations, or political parties, and costs incurred to improve community or public relations. This does not include membership dues;

(m) Vending machine expenses;

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

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

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

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

(s) Penalties and fines;

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

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

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

((~~(w)~~)) (v) Costs of special care services except where authorized by the department;

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

((~~(y)~~)) (x) Expenses of profit-sharing plans;

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

((~~(aa)~~)) (z) Personal expenses and allowances of any nursing home employees or owners or relatives of any nursing home employees or owners;

((~~(bb)~~)) (aa) All expenses of maintaining professional licenses or membership in professional organizations;

((~~(cc)~~)) (bb) Costs related to agreements not to compete;

((~~(dd)~~)) (cc) Amortization of goodwill, lease acquisition, or any other intangible asset, whether related to resident care or not, and whether recognized under generally accepted accounting principles or not;

((~~(ee)~~)) (dd) Expenses related to vehicles which are in excess of what a prudent contractor would expend for the ordinary and economic provision of transportation needs related to patient care;

((~~(ff)~~)) (ee) Legal and consultant fees in connection with a fair hearing against the department when the department's Board of Appeals upholds the department's actions in an administrative review decision. When the administrative review decision is pending, reported legal and consultant fees will be unallowable. To be allowable, the contractor must report legal and consultant fees related to an administrative review decision issued in the contractor's favor in the cost report period in which the Board of Appeals issues its decision irrespective of when the legal and consultant fees related to the administrative review were incurred;

((~~(gg)~~)) (ff) Legal and consultant fees of a contractor or contractors in connection with a lawsuit against the department. Judicial review is a lawsuit against the department;

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

((~~(ii)~~)) (hh) All rental or lease costs other than those provided for in WAC 388-96-580;

((~~(jj)~~)) (ii) Postsurvey charges incurred by the facility ((~~as a result of subsequent inspections~~)) under ((~~RCW 18.51.050 which occur beyond the first postsurvey visit during the certification survey calendar year~~)) RCW 18.51.060;

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

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

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

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

((~~(oo)~~)) (nn) Travel expenses that are not necessary, ordinary, and related to resident care;

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

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

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

((~~(ss)~~)) (qq) Payroll taxes associated with compensation in excess of allowable compensation of owners, relatives, and administrative personnel;

((~~(tt)~~)) (rr) Costs and fees associated with filing a petition for bankruptcy;

((~~(uu)~~)) (ss) All advertising or promotional costs, except reasonable costs of help wanted advertising;

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

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

~~(xx)~~)) (uu) Tax expenses that a nursing facility has never incurred;

((~~(yy)~~)) (vv) Effective July 1, 2007, and for all future rate settings, any costs associated with the quality maintenance fee repealed by chapter 241, Laws of 2006;

((~~(zz)~~)) (ww) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits against the department ((~~shall be~~)) are unallowable; and

((~~(aaa)~~)) (xx) Increased costs resulting from a series of transactions between the same parties and involving the same assets (e.g., sale and lease back, successive sales or leases of a single facility or piece of equipment)((~~.~~));

(yy) Costs related to a nursing assistant certified training program;

(zz) Effective July 1, 2012, payments made relating to the safety net assessment; and

(aaa) Building renovations, building improvements, or leasehold improvements that require preapproval from the department of health and were not preapproved.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-709 Prospective rate revisions—Reduction in licensed beds((~~ by means other than "banking" pursuant to chapter 70.38 RCW~~)). (1) For the purpose of minimum occupancy capital calculation banked beds are included in the number of licensed beds. The department will recalculate a contractor's prospective medicaid payment rate when the contractor permanently reduces the number of its licensed beds and:

(a) Provides a copy of the new bed license, if issued, documentation of the number of beds sold, exchanged or otherwise placed out of service, along with the name of the contractor that received the beds, if any, and the letter from the department of health (DOH) confirming the number of beds relinquished and the date they were relinquished; and

(b) Requests a rate revision.

(2) The department will revise medicaid rates in accordance with this chapter and chapter 74.46 RCW using the facility's decreased licensed bed capacity to calculate minimum occupancy for rate setting.

(3)((~~(a)~~)) When the new license is effective the first day of the month or when the DOH letter confirms the beds were relinquished the first day of the month, the revised prospective payment rate will be effective the first day of the month((~~; or~~)).

((~~(b)~~)) (4) When the new license is effective after the first day of the month or when the DOH letter confirms the beds were relinquished after the first day of the month, the revised prospective payment rate will be effective the first day of the month following the month the new license was effective or the DOH letter confirmed beds were relinquished after the first day of the month.

((~~(4)(a)~~)) (5) The department will recalculate a nursing facility's prospective medicaid payment rate allocations using the greater of actual days from the cost report period on which the rate is based or days calculated by multiplying the new number of licensed beds including banked bed times the appropriate minimum occupancy pursuant to this chapter and chapter 74.46 RCW times the number of calendar days

in the cost report period on which the rate being recalculated is based.

((~~(b) For all nursing facilities, occupancy is based on licensed beds, regardless of how many are set up or in use. For purposes of calculating minimum occupancy, licensed beds include any beds banked under chapter 70.38 RCW. For all nursing facilities, minimum facility occupancy of licensed beds for operations, property, and financing allowance component rate allocations shall be:~~

~~(i) Essential community providers - Eighty-five percent.~~

~~(ii) Small nonessential community providers - Ninety percent.~~

~~(iii) Large nonessential community providers - Ninety-two percent.~~

~~(c) For all nursing facilities, minimum facility occupancy of licensed beds for therapy and support services component rate allocations shall be eighty-five percent. For all nursing facilities, minimum facility occupancy of licensed beds for direct care component rate allocations shall be based upon actual facility occupancy.~~

~~(5)~~)) (6) The revised prospective medicaid payment rate will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums, unless otherwise specified in this section.

AMENDATORY SECTION (Amending WSR 01-12-037, filed 5/29/01, effective 6/29/01)

WAC 388-96-710 Prospective payment rate for new contractors. (1) The department will establish an initial prospective medicaid payment rate for a new contractor as defined under WAC 388-96-026 within sixty days following the new contractor's application and approval for a license to operate the facility under chapter 18.51 RCW. The rate will take effect as of the effective date of the contract, except as provided in this section, and will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums set forth.

(2) ((~~Except for quarterly updates per RCW 74.46.501 (7)(c), the rate established for a new contractor as defined in WAC 388-96-026 (1)(a) or (b) will remain in effect for the nursing facility until the rate can be reset effective July 1 using the first cost report for that facility under the new contractor's operation containing at least six months' data from the prior calendar year, regardless of whether reported costs for facilities operated by other contractors for the prior calendar year in question will be used to cost rebase their July 1 rates. The new contractor's rate thereafter will be cost rebased only as provided in this chapter and chapter 74.46 RCW.~~

~~(3)~~)) To set the initial prospective medicaid payment rate for a new contractor as defined in WAC 388-96-026 (1)(a) and (b), the department will:

(a) Determine ((~~whether the new contractor nursing facility belongs to the metropolitan statistical area (MSA) peer group or the non-MSA peer group using the latest information received from the office of management and budget or the appropriate federal agency~~)) the direct care rate by multiplying the industry median by the appropriate county wage index by the facility's medicaid average case mix index

(MACMI) and if the facility does not have a MACMI, the department will use the facility industry MACMI;

(b) ((~~Select all nursing facilities from the department's records of all the current medicaid nursing facilities in the new contractor's peer group with the same bed capacity plus or minus ten beds. If the selection does not result in at least seven facilities, then the department will increase the bed capacity by plus or minus five bed increments until a sample of at least seven nursing facilities is obtained~~)) Assign the new provider the indirect price based rate;

(c) ((~~Based on the information for the nursing facilities selected under subsection (3)(b) of this section and available to the department on the day the new contractor began participating in the medicaid payment rate system at the facility, rank from the highest to the lowest the component rate allocation in direct care, therapy care, support services, and operations cost centers and based on this ranking:~~

~~(i) Determine the middle of the ranking and then identify the rate immediately above the median for each cost center identified in subsection (3)(c) of this section. The rate immediately above the median will be known as the "selected rate" for each cost center;~~

~~(ii) Set the new contractor's nursing facility component rate allocation for therapy care, support services, and operations at the "selected rate";~~

~~(iii) Set the direct care rate using data from the direct care "selected" rate facility identified in (c) of this subsection as follows:~~

~~(A) The cost per case mix unit will be the rate base allowable case mixed direct care cost per patient day for the direct care "selected" rate facility, whether or not that facility is held harmless under WAC 388-96-728 and 388-96-729, divided by the facility average case mix index per WAC 388-96-741;~~

~~(B) The cost per case mix unit determined under (c)(iii)(A) of this subsection will be multiplied by the medicaid average case mix index per WAC 388-96-740. The product will be the new contractors direct care rate under case mix; and~~

~~(C) The department will not apply RCW 74.46.506 (5)(k) to any direct care rate established under subsection (5)(e) or (f) of this section. When the department establishes a new contractor's direct care rate under subsection (5)(e) or (f) of this section, the new contractor is not eligible to be paid by a "hold harmless" rate as determined under RCW 74.46.506 (5)(k);~~

~~(iv) Set the property rate in accordance with the provisions of this chapter and chapter 74.46 RCW; and~~

~~(v) Set the financing allowance and variable return component rate allocations in accordance with the provisions of this chapter and chapter 74.46 RCW. In computing the variable return component rate allocation, the department will use for direct care, therapy care, support services and operations rate allocations those set pursuant to subsection (3)(c)(i), (ii) and (iii) of this section.~~

~~(d) Any subsequent revisions to the rate component allocations of the sample members will not impact a "selected rate" component allocation of the initial prospective rate established for the new contractor under this subsection.~~

~~(4) For the WAC 388-96-026 (1)(a) or (b) new contractor, the department will establish rate component allocations for:~~

~~(a) Direct care, therapy care, support services and operations based on the "selected rates" as determined under subsection (3)(c) of~~

~~this section that are in effect on the date the new contractor began participating in the program;~~

~~(b) Property in accordance with the provisions of this chapter and chapter 74.46 RCW using for the new contractor as defined under:~~

~~(i) WAC 388-96-026 (1)(a), information from the certificate of need; or~~

~~(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the property rate will be zero. The property rate will remain zero until the information is received;~~

~~(c) Variable return in accordance with the provisions of this chapter and chapter 74.46 RCW using the "selected rates" established under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program; and~~

~~(d) Financing allowance using for the new contractor as defined under:~~

~~(i) WAC 388-96-026 (1)(a), information from the certificate of need; or~~

~~(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the net book value of allowable assets will be zero. The financing allowance rate component allocation will remain zero until the information is received.~~

~~(5) The initial prospective payment rate for a new contractor as defined under WAC 388-96-026 (1)(a) or (b) will be established under subsections (3) and (4) of this section. If the WAC 388-96-026 (1)(a) or (b) contractor's initial rate is set:~~

~~(a) Between July 1, 2000 and June 30, 2001, the department will set the new contractor's rates for:~~

~~(i) July 1, 2001 using the July 1, 2001 rates for direct care, therapy care, support services, and operations of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.~~

~~(A) Property and financing allowance component rates will remain the same as set for the initial rate.~~

~~(B) Variable return component rate using the rates determined under subsection (5)(a)(i) of this section;~~

~~(ii) July 1, 2002 rate using 2001 cost report data; and~~

~~(iii) All July 1 rates following July 1, 2002 in accordance with this chapter and chapter 74.46 RCW;~~

~~(b) Between July 1, 2001, and June 30, 2002, the department will set the new contractor's rates for:~~

~~(i) July 1, 2002 using July 1, 2002 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.~~

~~(A) Property and financing allowance component rates will remain the same as set for the initial rate.~~

~~(B) Variable return component rate using the rates determined under subsection (5)(b)(i) of this section;~~

~~(ii) July 1, 2003 rate by rebasing using 2002 cost report data in accordance with this chapter and chapter 74.46 RCW; and~~

~~(iii) All July 1 rates following July 1, 2003 in accordance with this chapter and chapter 74.46 RCW; or~~

~~(c) Between July 1, 2002, and June 30, 2003, the department will set the contractor's rates for:~~

~~(i) July 1, 2003 using July 1, 2003 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsection (3) and (4) of this section.~~

~~(A) Property and financing allowance component rates will remain the same as set for the initial rate.~~

~~(B) Variable return component rate using the rates determined under subsection (5)(c)(i) of this section;~~

~~(ii) July 1, 2004 by rebasing using 2003 cost report data; and~~

~~(iii) All July 1 rates following July 1, 2004 in accordance with this chapter and chapter 74.46 RCW.~~

~~(6) For the WAC 388-96-026 (1)(c) new contractor, the initial prospective payment rate will be the last prospective payment rate the department paid to the medicaid contractor operating the nursing facility immediately prior to the effective date of the new medicaid contract or assignment. If the WAC 388-96-026 (1)(c) contractor's initial rate is set:~~

~~(a) Between October 1, 1998 and June 30, 1999, the department will not rebase the contractor's rate for:~~

~~(i) July 1, 1999; and~~

~~(ii) July 1, 2000;~~

~~(b) Between July 1, 1999 and June 30, 2000, the department will for:~~

~~(i) July 1, 2000 not rebase the new contractor's rate;~~

~~(ii) July 1, 2001 rebase the new contractor's rate using twelve months of cost report data derived from the old contractor's and the new contractor's 1999 cost reports; and~~

~~(iii) July 1, 2002 not rebase the new contractor's rate; and~~

~~(iv) July 1, 2003 not rebase the new contractor's rate;~~

~~(c) Between July 1, 2000 and June 30, 2001, the department will for:~~

~~(i) July 1, 2001 rebase the new contractor's rate using the old contractor's 1999 twelve month cost report;~~

~~(ii) July 1, 2002 not rebase the new contractor's rate;~~

~~(iii) July 1, 2003 not rebase the new contractor's rate; or~~

~~(d) Between July 1, 2001 and June 30, 2002, the department will for:~~

~~(i) July 1, 2002 not rebase the new contractor's rate;~~

~~(ii) July 1, 2003 not rebase the new contractor's rate; and~~

~~(iii) July 1, 2004 rebase the new contractor's rate using the new contractor's 2002 cost report containing at least six month's data.~~

~~(7)~~)) Determine a capital rate once the facility has submitted square footage and age information and the department accepts it; and

(d) Use the facility's available centers for medicare and medicaid date for the three quarter period currently being measured by the department to determine a quality enhancement rate and if no data is available, the department will not pay a quality enhancement.

(3) A prospective payment rate set for all new contractors will be subject to adjustments for economic trends and conditions as authorized and provided in this chapter and in chapter 74.46 RCW.

((~~(8) For a WAC 388-96-026 (1)(a), (b) or (c) new contractor, the medicaid case mix index and facility average case mix index will be determined in accordance with this chapter and chapter 74.46 RCW.~~))

AMENDATORY SECTION (Amending WSR 04-21-027, filed 10/13/04, effective 11/13/04)

WAC 388-96-713 Rate determination. (1) Each nursing facility's medicaid payment rate for services provided to medical care recipients will be determined, adjusted and updated prospectively as provided in this chapter and in chapter 74.46 RCW. The department will calculate any limit, ((~~lid,~~)) and/or median only when it rebases each nursing facility's July 1st medicaid payment rate in accordance with chapter 74.46 RCW and this chapter.

(2) If the contractor participated in the program for less than six months of the prior calendar year, its rates will be determined by procedures set forth in WAC 388-96-710.

(3) Contractors submitting correct and complete cost reports by March 31st, ((~~shall~~)) must be notified of their rates by July 1st, unless circumstances beyond the control of the department interfere.

(4) In setting rates, the department will use the greater of actual days from the cost report period on which the rate is based or days calculated at minimum occupancy pursuant to chapter 74.46 RCW.

((~~(5) Adjusted cost report data from 1999 shall be used for July 1, 2001 through June 30, 2005 direct care, therapy care, support services, and operations component rate allocations.~~))

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-758 Add-on for low-wage workers. (1) The department will grant a low wage add-on payment not to exceed one dollar and fifty-seven cents per resident day to any nursing home provider that has indicated a desire to receive the add-on pursuant to subsection (7) of this section. A nursing home may use the add-on only for in-house staff and not for allocated, home office, or purchased service increases. A nursing home may use the add on to:

(a) Increase wages, benefits, and/or staffing levels for certified nurse aides;

(b) Increase wages and/or benefits but not staffing levels for dietary aides, housekeepers, laundry aides, or any other category of worker whose statewide average dollars-per-hour wage was less than fifteen dollars in calendar year 2008, according to cost report data. The department has determined that the additional categories of workers qualifying under this standard are:

(i) Activities directors and assistants;

(ii) Patient choices coordinators;

(iii) Central supply/ward clerks;

(iv) Expanded community service workers; and

(v) Social workers; and

(c) Address wage compression for related job classes immediately affected by wage increases to low-wage workers.

(2) A nursing home that receives a low-wage add-on ((~~shall~~)) must report to the department its expenditure of that add-on by:

(a) Completing Cost Report Schedule L 1; and

(b) Returning it to the department by January 31st.

(3) By examining Cost Report Schedule L 1, the department will determine whether the nursing home complied with the statutory requirements for distribution of the low wage add-on. When the department is unable to determine or unsure that the statutory requirements have been met, it will conduct an on site audit.

(4) When the department determines that the statutory requirements have been met, the low wage add-on will be reconciled at the same time as the regular settlement process but as a separate reconciliation. The reconciliation process will compare gross dollars received in the add-on to gross dollars spent.

(5) When the department determines that the low wage add-on has not been spent in compliance with the statutory requirements, then it will recoup the noncomplying amount as an overpayment.

(6) The department also will require the completing of Cost Report Schedule L 1 for any calendar year in which the low wage add-on is paid for six months or more. Subsections (1) through (5) of this section will apply to all completions of Cost Report Schedule L 1 irrespective of the calendar year in which it is paid.

(7) Each May of the calendar year, the department will ask nursing home contractors whether they will want to continue to receive the add-on or begin to receive the add-on. For nursing home contractors responding by May 31st indicating a desire to receive the low wage worker add-on, the department will pay them the low wage add-on effective July 1st. For nursing home contractors that do not respond by May 31st indicating a desire to receive the low wage worker add-on, the department will cease or not begin paying them the low wage add-on effective July 1st.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-781 Exceptional care rate add-on—Covered medicaid residents. A nursing facility (NF) may receive an increase in its direct care ((~~and/or therapy component~~)) rate allocations for providing exceptional care to a medicaid resident who:

(1) Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children and resides in a NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen;

(2) Receives expanded community services (ECS);

(3) Is admitted to the NF as an extraordinary medical placement (EMP) and the department of corrections (DOC) has approved the exceptional direct care and/or therapy payment;

(4) Is ventilator or tracheotomy (VT) dependent and resides in a NF that the department has designated as active ventilator-weaning center;

(5) Has a traumatic brain injury (TBI) established by a comprehensive assessment reporting evaluation (CARE) assessment administered by department staff and resides in a NF that the department has designated as capable for TBI patients;

(6) Has a TBI and currently resides in nursing facility specializing in the care of TBI residents where more than fifty percent of

residents are classified with TBIs based on the federal minimum data set assessment (MDS ((~~2~~)) 3.0 or its successor); or

(7) Is admitted to a NF from a hospital with an exceptional care need and medicaid purchasing administration (MPA) or a successor administration has approved the exceptional direct care ((~~and/or therapy~~)) payment.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-782 Exceptional ((~~therapy care and exceptional~~)) direct care~~—~~Payment. (1) For WAC 388-96-781(1) residents, the department will pay the Oregon medicaid rate.

(2) For WAC 388-96-781 (4), (5)((~~—and~~)), (6), and residents, the department may establish a rate add-on that when added to the nursing facility's per diem medicaid rate does not exceed the cost of caring for the client in a hospital.

((~~(3)(a) Costs related to payments resulting from increases in direct care component rates under subsection (2) of this section shall be offset against the facility's examined, allowable direct care costs, for each report year or partial period such increases are paid. Such reductions in allowable direct care shall be for rate setting, settlement, and other purposes deemed appropriate by the department; or~~

~~(b) Costs related to payments resulting from increases in therapy care component rates under subsection (2) of this section shall not be offset against the facility's examined, allowable therapy care costs, for each report year or partial period such increases are paid.~~))

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-901 Disputes. (1) When a contractor wishes to contest the way in which the department applied a statute or department rule to the contractor's circumstances, the contractor ((~~shall~~)) must pursue the administrative review process prescribed in WAC 388-96-904.

(a) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW subject to administrative review under WAC 388-96-904 include but are not limited to the following:

(i) Determining a nursing facility payment rate;

(ii) Calculating a nursing facility settlement;

(iii) Imposing a civil fine on the nursing facility;

(iv) Suspending payment to a nursing facility; or

(v) Conducting trust fund and accounts receivable audits.

(b) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW not subject to administrative review under WAC 388-96-904 include but are not limited to:

(i) Actions taken under the authority of RCW 74.46.421 and sections of this chapter implementing RCW 74.46.421;

(ii) Case mix accuracy review of minimum data set (MDS) nursing facility resident assessments, which ((~~shall~~)) must be limited to separate administrative review under the provisions of WAC 388-96-905;

(iii) ((~~Quarterly and~~)) Semiannual rate updates to reflect changes in a facility's resident case mix including contractor errors made in the MDSs used to update the facility's resident case mix;

(iv) Actions taken under exceptional direct ((~~and therapy~~)) care program codified at WAC 388-96-781 and 388-96-782;

(v) Actions taken under WAC 388-96-218 (2)(c)((~~; and~~

~~(vi) Actions taken under WAC 388-96-786~~)).

(2) The administrative review process prescribed in WAC 388-96-904 ((~~shall~~)) must not be used to contest or review unrelated or ancillary department actions, whether review is sought to obtain a ruling on the merits of a claim or to make a record for subsequent judicial review or other purpose. If an issue is raised that is not subject to review under WAC 388-96-904, the presiding officer ((~~shall~~)) must dismiss such issue with prejudice to further review under the provisions of WAC 388-96-904, but without prejudice to other administrative or judicial review as may be provided by law. Unrelated or ancillary actions not eligible for administrative review under WAC 388-96-904 include but are not limited to:

(a) Challenges to the adequacy or validity of the public process followed by department in proposing or making a change to the nursing facility medicaid payment rate methodology, as required by Title 42 U.S.C. Sec. 1396a((–))(a)(13)(A) and WAC 388-96-718;

(b) Challenges to the nursing facility medicaid payment system that are based in whole or in part on federal laws, regulations, or policies;

(c) Challenges to a contractor's rate that are based in whole or in part on federal laws, regulations, or policies;

(d) Challenges to the legal validity of a statute or regulation; and

(e) Actions of the department affecting a medicaid beneficiary or provider that were not commenced by the office of rates management, aging and ((~~disability services~~)) long-term support administration((~~, for example, entitlement to or payment for durable medical equipment or other services~~)).

(3) If a contractor wishes to challenge the legal validity of a statute, rule, or contract provision relating to the nursing facility medicaid payment system or wishes to bring a challenge based in whole or in part on federal law, it must bring such action de novo in a court of proper jurisdiction as may be provided by law. The contractor ((~~may~~)) must not use this section or WAC 388-96-904 for such purposes. This prohibition ((~~shall apply~~)) applies irrespective of whether the contractor wishes to obtain a decision or ruling on an issue of validity or federal compliance or wishes only to make a record for the purpose of subsequent judicial review.

NEW SECTION

WAC 388-96-915 Capital component—Square footage. (1) Allowable nursing home square footage is the external dimensions of the space building utilized and licensed as a nursing home less all unallowable

square footage as outlined in subsection (2) of this section. Allowable nursing home square footage includes the following:

(a) All necessary, ordinary, and reasonable space on the campus or adjacent to the campus utilized by the residents and staff of the nursing home including in administrative and support capacities; and

(b) Basements to the extent they are utilized for administrative or support functions including the storage of equipment and records.

(2) Unallowable nursing home square footage includes, but is not limited to:

(a) Courtyards or other areas not surrounded by four walls and a contiguous roof;

(b) Patios and decks; and

(c) Off-site storage space.

(3) Off-site administrative square footage is allowable to the extent it is:

(a) Allocated in accordance with an approved joint cost allocation disclosure as outlined in WAC 388-96-534;

(b) Not otherwise unallowable under subsection (2) of this section; and

(c) Used for administrative purposes.

(4) Off-site administrative square footage is allowable up to ten percent of the combined total allowable square footage. Any square footage over ten percent of the combined total allowable square footage in unallowable.

(5) In order to be allowable, all space must be identified on a site plan, blueprint, or county assessment identifying the gross external square footage.

NEW SECTION

WAC 388-96-916 Capital component—Facility age. (1) Facility age is based on the completion date of the original structure as adjusted for renovations as defined in WAC 388-96-020.

(2) For the cost report period ending December 31, 2014, facility age will be calculated by identifying the square footage and date placed into service for the original structure and renovations.

(3) Beginning with rates paid on July 1, 2016, the average age of a facility is the age as calculated on the calendar year 2014 cost report adjusted by renovations reported in 2015.

(4) Beginning with rates paid on July 1, 2017, the average age of a facility will be adjusted on July 1st of each year based on renovations from the prior calendar year cost reporting period.

(5) Average age is calculated in accordance with RCW 74.46.561(5)(e).

NEW SECTION

WAC 388-96-917 Direct care—County wage information. (1) The department must calculate a county wide wage index each rebase year by utilizing the most recent average wage data available from the federal

bureau of labor statistics for registered nurses, licensed practical nurses, and certified nursing assistants.

(2) For each county, the department must calculate an average combined wage for all three disciplines based on the percentage of total wages by discipline from the prior year cost report. Each wage must be multiplied by the relative utilization percentage for that discipline. The total of all three disciplines is the average wage in that county.

(3) The department must calculate the statewide average combined wage for all three disciplines based on the average percentage of total wages by discipline from the prior year cost report.

(4) The county index is determined by dividing the county average wage in a given county by the statewide average wage.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-96-540	Will the department allow the cost of an administrator-in-training?
WAC 388-96-552	Depreciable assets.
WAC 388-96-553	Capitalization.
WAC 388-96-554	Expensing.
WAC 388-96-558	Depreciation expense.
WAC 388-96-559	Cost basis of land and depreciation base.
WAC 388-96-561	Cost basis of land and depreciation base—Donated or inherited assets.
WAC 388-96-562	Depreciable assets—Disposed—Retired.
WAC 388-96-564	Methods of depreciation.
WAC 388-96-565	Lives.
WAC 388-96-572	Handling of gains and losses upon retirement of depreciable assets—Other periods.
WAC 388-96-574	New or replacement construction—Property tax increases.
WAC 388-96-708	Beds removed from service under chapter 70.38 RCW, new beds approved under chapter 70.38 RCW, and beds permanently relinquished—Effect on prospective payment rate.
WAC 388-96-744	How will the department set the therapy care rate and determine the median cost limit per unit of therapy?
WAC 388-96-746	How much therapy consultant expense for each therapy type will the department allow to be added to the total allowable one-on-one therapy expense?

WAC 388-96-747	Constructed, remodeled or expanded facilities.
WAC 388-96-748	Financing allowance component rate allocation.
WAC 388-96-759	Standards for low-wage workers add-on.
WAC 388-96-762	Allowable land.
WAC 388-96-767	Appraisal values.
WAC 388-96-776	Add-ons to the property and financing allowance payment rate—Capital improvements.
WAC 388-96-783	Certificate of capital authorization (CCA).
WAC 388-96-784	Expense for construction interest.
WAC 388-96-786	Pay for performance add-on.