

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

LIFE CARE CENTERS OF AMERICA, INC., et al.,

Appellants

vs.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES, STATE OF
WASHINGTON,

Respondent.

APPELLANTS' OPENING BRIEF

INSLEE, BEST, DOEZIE & RYDER, P.S.
John F. Sullivan, W.S.B.A. #15426
Attorneys for Appellants
777 - 108th Avenue N.E., Suite 1900
Bellevue, WA 98004
P.O. Box 90016
Bellevue, Washington 98009-9016
Telephone: 425-455-1234

FILED
MAY 27
STATE OF WASHINGTON
COURT OF APPEALS

TABLE OF CONTENTS

I. INTRODUCTION 1

II. ASSIGNMENTS OF ERROR 2

III. STATEMENT OF THE CASE..... 3

IV. ARGUMENT 6

 1. Standard of Review..... 6

 2. The Department's use of case mix weights based on 1999 costs for the FACMI calculation is contrary to the requirement in RCW 74.46.431(4)(a) that adjusted cost report data from 2005 be used in the rate calculation..... 7

 3. The Department's treatment of the FACMI is contrary to the plain language of RCW 74.46.496(4) and (5) that require the revision to the case mix weights is “to be effective on the July 1 effective date of each cost rebase direct care component rate.” 9

 4. The Department improperly construes RCW 74.46.501(7)(b)(iii) as being in conflict with RCW 74.46.431(4)(a) and RCW 74.46.496(4) and (5). 13

V. CONCLUSION..... 18

TABLE OF AUTHORITIES

Cases

Anderson vs. Dep't of Corr.,
159 Wn.2d 849, 861, 154 P.3d 220 (2007)..... 14

Appren. Comm. v. Training Council,
131 Wn. App. 862, 879, 129 P.2d 838 (2006) 14

Davis vs. Employment Sec. Dep't,
108 Wn.2d 272, 276, 737 P.2d 1262 (1987) 15

Employco Pers. Servs., Inc. vs. City of Seattle,
117 Wn.2d 606, 614, 817 P.2d 1373 (1991) 14

Franklin County Sheriff's Office vs. Sellers,
96 Wn.2d 317, 323-324, 646 P.2d 113 (1982),
cert. denied, 459 U.S. 1106 (1983)6

Green River Comm. College vs. Higher Educ. Personnel Bd.,
95 Wn.2d 108, 112, 622 P.2d 826 (1980),
modified in part 95 Wn.2d 962, 633 P.2d 1324 (1981) 12

Haley vs. Medical Disciplinary Board,
117 Wn.2d 720, 728, 818 P.2d 1062 (1991)6

State ex. rel. Citizens vs. Murphy,
151 Wn.2d 226, 242, 88 P.3d 375 (2004) 12, 14

Vergeyle vs. Employment Sec. Dep't.,
28 Wn. App. 399, 404, 623 P.2d 736 (1981) 14

Waste Management vs. WUTC,
123 Wn.2d 621, 627, 869 P.2d 1034 (1994) 12

Regulations

WAC Chapter 388-96.....1

Statutes

RCW 18.51.3501
RCW 34.05.570(3)(d)6
RCW Chapter 74.461
RCW 74.46.431 15
RCW 74.46.431(1).....2
RCW 74.46.431(4)..... 10
RCW 74.46.431(4)(a)2, 5, 7, 8, 13, 14, 15
RCW 74.46.496 9, 11, 13, 15, 17
RCW 74.46.496(4)..... 2, 5, 9, 10, 11, 12, 13, 14, 15, 17, 18
RCW 74.46.496(5)..... 2, 5, 9, 10, 11, 12, 13, 14, 15, 17, 18
RCW 74.46.5018, 15, 17
RCW 74.46.501(1).....4
RCW 74.46.501(7)(b)(iii).....8, 13, 15
RCW 74.46.506(1).....3
RCW 74.46.506(5)(d)4
RCW 74.46.660(4).....1

I. INTRODUCTION

This matter arises under the nursing facility Medicaid payment system set forth in RCW Chapter 74.46, and WAC Chapter 388-96. Medicaid is a joint federal-state program. The Respondent, the Department of Social and Health Services (the "Department"), is charged with administering the Medicaid program but must comply with federal requirements as a condition of receiving federal financial participation. See, RCW 18.51.350. The Appellant nursing facilities (the "Facilities")¹ contract with the Department to provide nursing facility services to Medicaid-eligible residents. See, RCW 74.46.660(4). In exchange for providing these services, the Department pays the Facilities rates calculated pursuant to the payment system outlined in RCW Chapter 74.46, and WAC Chapter 388-96.

This appeal relates to the establishment of the Facilities' payment rates effective July 1, 2007. The July 1, 2007, Medicaid rates are intended to pay for services provided by the Facilities to Medicaid-eligible residents between July 1, 2007, and June 30, 2008. The payment rates are established in the following component areas: direct care, therapy care, support services, operations, property,

financing allowance, and variable return. RCW 74.46.431(1). In general, payment rates are set based upon a previous year's "allowable costs" that have been vetted and approved by the Department.

II. ASSIGNMENTS OF ERROR

Assignment of Error No. 1

The Department's presiding officer erred in Conclusion of Law Nos. 7 and 9 that the Department is not required to revise the Facilities' case mix weights used in the FACMI calculation for purposes of setting the Facilities' July 1, 2007, direct care Medicaid rates.

Issues Pertaining to Assignments of Error

1. Whether the Department's use of case mix data from 1999 is contrary to the requirement in RCW 74.46.431(4)(a) that the Department use 2005 adjusted cost data in setting the Facilities' July 1, 2007, Medicaid rates.

2. Whether the Department's failure to revise the case mix weights used in the FACMI calculation is contrary to RCW 74.46.496(4) and (5).

¹ The Facilities are listed in **Appendix A** hereto.

3. Whether the Legislature has authorized the Department to use case mix weights that are based on 1999 wage data when revised case mix weights based on 2005 wage data was available at the time that the Facilities' July 1, 2007, direct care Medicaid rates were set.

III. STATEMENT OF THE CASE

The issue in this case deals with the Facilities' direct care component rates. The direct care component rate pays for the provision of nursing care and nursing supplies to Medicaid residents. RCW 74.46.506(1).

The Facilities' direct care component rates are determined based upon a case mix system; a complex acuity based system which is designed to more closely align the direct care payment rate to the needs of the Facilities' Medicaid residents. RP 15. Each nursing facility resident is assigned a case mix weight based upon the acuity level of the resident. RP 15-16. From the case mix weights, the Department determines two average case mix indexes for each nursing facility: (i) a Medicaid average case mix index ("MACMI"), which is the case mix index for all of the facility's Medicaid residents; and (ii) a facility average case mix index ("FACMI"), which is the case mix index for all

of the facility's residents – including its Medicaid and non-Medicaid residents. RP 17; see, also, RCW 74.46.501(1).

The FACMI and the MACMI both play a key role in the determination of each facility's direct care component rate. The FACMI is used to determine each facility's cost per case mix unit. RP 21. First, the facility's allowable direct care costs per resident day are vetted and adjusted by the Department. AR 563 (Item 42).² The direct care costs that survive the Department's review and adjustment are called the "adjusted direct care costs." AR 563 (Item 43). The facility's adjusted direct care costs are then divided by the FACMI to determine the facility's allowable direct care cost per case mix unit. AR 563 (Item 45); see, also, RCW 74.46.506(5)(d).

The direct care cost per case mix unit is then used to determine each facility's direct care rate. AR 563 (Items 38 and 45). Subject to certain limits or corridors, the direct care cost per case mix unit is multiplied by the facility's MACMI, to determine the facility's direct care rate. Id. (Items 48 and 49).

² Citations to the administrative record below are identified as "AR." This particular citation is to Ex 1, page 2, which is at Appendix E.

So the process to establish each facility's direct care component rate can be summarized as follows: the facility's adjusted allowable direct care costs are divided by the FACMI and then multiplied by the MACMI to determine the facility's direct care component rate.

From time to time the cost base year is "rebased" to update the costs used to determine the adjusted allowable costs. See, RCW 74.46.431(4)(a). For example, for several rate periods prior to July 1, 2006, the base year used to determine adjusted allowable direct care costs was 1999. In the July 1, 2006 rate setting, the base year was updated to 2003. Id. In the July 1, 2007, rate setting, the base year used to determine the direct care adjusted allowable costs was updated to 2005. Id.

When the direct care component rates are cost rebased, as was done in the July 1, 2006 and July 1, 2007 rate settings, the Department is also required to revise the case mix weights. RCW 74.46.496(4) and (5); and RP 16. The Department revised the case mix weights in the July 1, 2007 rate setting, but did not incorporate the revised case mix weights in the FACMI portion of the calculation. RP 23 and 45. The

Department only used the revised case mix weights in the MACMI portion of the calculation. RP 45.

As a result, while each facility's MACMI was based upon 2005 cost data in the July 1, 2007 rate calculation, the facility's FACMI continued to be based upon 1999 cost data. RP 65.

IV. ARGUMENT

1. Standard of Review.

This matter is a judicial review of a Decision and Final Order issued by the Department. As such, the Court's review is based upon the agency record and decision, and not upon the trial court's decision. See, Franklin County Sheriff's Office vs. Sellers, 96 Wn.2d 317, 323-324, 646 P.2d 113 (1982), cert. denied, 459 U.S. 1106 (1983).

The Department's legal determinations are reviewed under an error of law standard, which permits the court to substitute its judgment for that of the agency. See, RCW 34.05.570(3)(d); see, also, Haley vs. Medical Disciplinary Board, 117 Wn.2d 720, 728, 818 P.2d 1062 (1991).

2. **The Department's use of case mix weights based on 1999 costs for the FACMI calculation is contrary to the requirement in RCW 74.46.431(4)(a) that adjusted cost report data from 2005 be used in the rate calculation.**

The Department recognizes that its position results in the use of wage data that is approximately 8 years old as one element in setting the July 1, 2007 Medicaid rates. RP 39, 45, 48, and 56. This position is directly contrary to RCW 74.46.431(4)(a) which requires that the Department use 2005 adjusted cost report data in setting the Facilities' July 1, 2007 rates. RCW 74.46.431(4)(a) provides, in part, as follows:

Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. . . . Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. . . .

The Department mostly followed RCW 74.46.431(4)(a) in setting the Facilities' July 1, 2007, Medicaid rates. The Department used 2005 adjusted cost report data for patient days, allowable costs, the MACMI calculation, and virtually everything else in the rate calculation *except for the FACMI calculation*. For purposes of the FACMI calculation, the Department continued to use the case mix weights based upon 1999 adjusted cost report data. RP 65.

No statute or regulation authorizes the Department to use 1999 adjusted cost report data in setting the Facilities' July 1, 2007, direct care rates. RCW 74.46.431(4)(a) only authorizes the use of 1999 adjusted cost report data for the rates effective from July 1, 2001, through June 30, 2006. The statute clearly requires the use of 2005 adjusted cost report data in setting the July 1, 2007, Medicaid rates.

The Department relies on RCW 74.46.501(7)(b)(iii) to support its position. However, RCW 74.46.501(7)(b)(iii), unlike RCW 74.46.431(4)(a), does not address what cost data is to be used in the rate calculation. The Department's presiding officer even acknowledged that RCW 74.46.501 does not state that the Department is to continue to use the old 1999 case mix weights in the July 1, 2007, rate setting. RP 42.

The Department's use of 1999 data for one part of the rate calculation (the FACMI) but 2005 data for everything else does not make sense. The faulty analysis supporting the Department's position is clearly evident from the disjointed formula that it followed in setting the Facilities July 1, 2007 direct care rates: 2005 adjusted allowable direct care costs per patient day (which are based on 2005 patient days and

2005 allowable costs) were divided by a FACMI that is based upon case mix weights from 1999, and then the result was multiplied by a MACMI that is based upon 2005 case mix weights. The formula used by the Department is incoherent because it relies upon data sources that are from vastly different time periods.

There is no rational basis for using the 1999 case mix weights in the FACMI calculation for the July 1, 2007 Medicaid rate setting when the 2005 revised case mix weights were readily available and could easily have been incorporated as was done for the MACMI calculation.

3. **The Department's treatment of the FACMI is contrary to the plain language of RCW 74.46.496(4) and (5) that require the revision to the case mix weights is "to be effective on the July 1 effective date of each cost rebase direct care component rate."**

The Department's failure to use the revised case mix weights in the FACMI for the July 1, 2007, rate setting violates the express language of RCW 74.46.496, which provides, in pertinent part, as follows:

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. *The case mix weights shall be revised, but only*

when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

(5) Case mix weights shall be revised when direct care component rates are cost rebased as provided in RCW 74.46.431(4).
(Emphasis added.)

RCW 74.46.496(4) and (5) unequivocally require the Department to revise the case mix weights when the direct care component rates are cost rebased. The Department concedes that it normally revises the case mix weights when a rebasing occurs. RP 16. Although the direct care component rates were rebased in the July 1, 2007 rate setting, the Department did not revise the case mix weights for the FACMI. RP 45. Instead, the Department continued to use the old 1999 case mix weights for the FACMI in the July 1, 2007 rate setting. RP 39, 45, 48, and 56.

The Department acknowledges that it treated the case mix weights for the MACMI differently than it did for the FACMI in the July 1, 2007 rate setting. RP 50. The Department pursued this action even though it

concedes that RCW 74.46.496 does not allow it to treat the MACMI any different than the FACMI. RP 50. The plain language of RCW 74.46.496 does not distinguish between the MACMI and the FACMI. Rather, the plain language of the statute clearly shows that the Legislature intended that the Department revise the case mix weights for *both* the MACMI and the FACMI when rates are cost-rebased.

It is critical that both the MACMI and the FACMI be determined using the same case mix weights. The MACMI and the FACMI are both parts of the same equation for determining the Facilities' direct care component rates. As previously stated, the direct care component rates are essentially the result of the following formula: (Adjusted allowable direct care costs/FACMI) x MACMI. If different case mix weights are used in one part of the formula (MACMI) than in the other (FACMI), the rates will be skewed and will not correctly reflect the costs of providing care to Medicaid residents.

The Department's logic-defying position violates a basic tenet of statutory construction by effectively amending or nullifying RCW 74.46.496(4) and (5) under the guise of interpretation. See, Green River Comm. College vs. Higher Educ. Personnel Bd., 95 Wn.2d 108,

112, 622 P.2d 826 (1980), *modified in part* 95 Wn.2d 962, 633 P.2d 1324 (1981). The Department seeks to add a condition to the statute which would allow it to revise the case mix weights for only the MACMI and not the FACMI. But RCW 74.46.496(4) and (5) do not distinguish between the MACMI and the FACMI. Instead of adding terms to the statute, the Department is required to give effect to its plain meaning as an expression of legislative intent. State ex. rel. Citizens vs. Murphy, 151 Wn.2d 226, 242, 88 P.3d 375 (2004).

In light of its failure to follow the plain language of the statute, no deference should be afforded to the Department's "interpretation" of the statute. The Court, not the Department, retains the ultimate authority to interpret statutes. Waste Management vs. WUTC, 123 Wn.2d 621, 627, 869 P.2d 1034 (1994). There is no need for the Department's expertise in construing an unambiguous statute. Id. at 628. Further, the Courts do not defer to an agency determination which conflicts with a statute. Id. (citation omitted). Rather, where a statute is unambiguous, as is the case here, the Court determines the Legislature's intent from the language of the statute alone. Id. (citations omitted).

The Department's violation of RCW 74.46.496 is even more egregious in light of the fact that the Department has revised the case mix weights *twice* since 1999, but it persists in using the stale 1999 case mix weights in the FACMI calculation. RP 34, 44 and 56. The only purpose served by the Department's refusal to apply the revised case mix weights for the FACMI is to intentionally and artificially lower the Facilities' direct care rates. By not updating the case mix weights based upon 2005 cost data, the Department understates the actual cost per case mix unit for the 2005 base year. RP 63.³ This is not a proper exercise of the Department's authority.

4. The Department improperly construes RCW 74.46.501(7)(b)(iii) as being in conflict with RCW 74.46.431(4)(a) and RCW 74.46.496(4) and (5).

The Department construes RCW 74.46.501(7)(b)(iii) as allowing it to *not* revise the case mix weights used in the FACMI when the rates are cost rebased. The Department's interpretation of RCW 74.46.501(7)(b)(iii) conflicts with the express requirement in

³ This is evident from a comparison of Exhibits D and E which show that the wage ratios for both RNs and LPNs have increased between 1999 and 2005. Compared to the wages of a CNA, the wage ratio for RNs has increased from

RCW 74.46.496(4) and (5) that the Department revise the case mix weights when the rates are cost rebased, and is in conflict with the requirement in RCW 74.46.431(4)(a) that the Department use 2005 adjusted cost data in the rate calculation.

The Department's conflicting interpretations of these three statutory sections violates another fundamental tenet of statutory construction. Statutes which relate to the same subject matter must be read "as a unified whole to the end that a harmonious statutory scheme evolves which maintains the integrity of the respective statutes. Anderson vs. Dep't of Corr., 159 Wn.2d 849, 861, 154 P.3d 220 (2007); and Employco Pers. Servs., Inc. vs. City of Seattle, 117 Wn.2d 606, 614, 817 P.2d 1373 (1991). It must be assumed that the Legislature does not intend to create an inconsistency. State ex. rel. Citizens vs. Murphy, 151 Wn.2d 226, 245, 88 P.3d 375 (2004).

Furthermore, the Department may not treat similar situations in different ways. Appren. Comm. v. Training Council, 131 Wn. App. 862, 879, 129 P.2d 838 (2006), *citing* Vergeyle vs. Employment Sec. Dep't., 28 Wn. App. 399, 404, 623 P.2d 736 (1981), *overruled on other*

2.13 to 2.29, and the wage ratio for LPNs has increased from 1.66 to 1.82.

grounds in Davis vs. Employment Sec. Dep't, 108 Wn.2d 272, 276, 737 P.2d 1262 (1987). Despite these rules of statutory construction, the Department construes the statutes as being in conflict, and construes them in one fashion for the MACMI and in a different fashion for the FACMI.

Notwithstanding the Department's outcome-driven interpretation, RCW 74.46.431, .496, and .501 are not in conflict and can be construed together. The direction in RCW 74.46.501(7)(b)(iii) to use the average of facility case mix indexes from the four quarters occurring during the cost report period used to rebase the rate (2005) is consistent with: (a) the requirement in RCW 74.46.496(4) and (5) to revise the case mix weights when rates are cost rebased; and (2) the requirement in RCW 74.46.431(4)(a) to use 2005 adjusted cost report data. All three statutory provisions express a requirement to use 2005 data in the July 1, 2007 rate calculation, and not the 1999 data that was used by the Department in the FACMI calculation.

When all three statutory sections are read together and effect is given to each statute, it is clear that the Department is required to update

the average of the FACMI from the four quarters of 2005 using the 2005 revised case mix weights. This is what the Department did with the MACMI calculation that was used in the July 1, 2007, rate setting. The Department took the MACMI from the first quarter of 2007, which was originally determined based upon case mix weights from 2003, and then the Department revised the case mix weights in the MACMI based upon 2005 data. AR 23-24, and 46.⁴ The Department's witness (Ken Callaghan) testified as follows at RP 46:

- Q [by
Mr. Sullivan] Okay. And did the Department take the
MACMI from the first quarter of 2007
in that July 1, 2007, rate calculation?
- A Yes.
- Q Okay. But the Department went one
step further with that MACMI and it
recalibrated the case mix weights?
- A Yes.
- Q So not only did the Department take the
MACMI from the first quarter of 2007,

⁴ The MACMI from the first quarter of 2007 was originally based upon the case mix weights from 2003 because the MACMI had been updated in the July 1, 2006 rate calculation. In the July 1, 2007 rate calculation, the Department further updated the case mix weights used in the MACMI based upon 2005 cost data. The Department then applied the updated case mix weights to the MACMI from the first quarter of 2007.

but the Department also recalibrated the wage rates - I'm sorry - the case mix weights up to 2005 cost; is that correct?

A For July, yes.

The Department acknowledges that RCW 74.46.496 does not permit it to treat the MACMI any different than the FACMI. AR 50. Nevertheless, the Department took the additional step to update the case mix weights for the MACMI but failed to do so for the FACMI. The Department must be ordered to update the case mix weights for the FACMI as well.

Contrary to the Department's position, RCW 74.46.501 does not override the requirements of RCW 74.46.496(4) and (5) and does not otherwise allow the Department to treat the MACMI differently than the FACMI. The Department's presiding officer even noted below that RCW 74.46.501 does not state that the Department may continue to use the old 1999 case mix weights in the July 1, 2007 rate setting. RP 42. Again, there is no statutory provision that allows the Department to continue to use the old 1999 case mix weights in the July 1, 2007 rate setting.

In sum, the Department must be ordered to comply with RCW 74.46.496(4) and (5) and revise the case mix weights for the FACMI in the calculation of the Facilities' July 1, 2007, direct care component rates.

V. CONCLUSION

For the foregoing reasons, the Facilities request that the Department's determination on the FACMI issue be reversed. This matter should be remanded to the Department with a directive that the Department apply the revised case mix weights in the FACMI for purposes of calculating the Facilities' July 1, 2007, direct care rates.

RESPECTFULLY SUBMITTED this 13th of July, 2010.

INSLEE, BEST, DOEZIE & RYDER, P.S.

By 
John F. Sullivan, WSBA #15426
Attorneys for Appellants

VI. APPENDIX

- A. List of Appellant Facilities
- B. RCW 74.46.431
- C. RCW 74.46.496
- D. RCW 74.46.501
- E. AR 562-568 (Exhibit 1)

List of Appellant Facilities

Life Care Centers of America, Inc., a Tennessee corporation, doing business as Life Care Center of Bothell; Life Care Center of Kennewick; Life Care Center of Richland; and Life Care Center of Ritzville

Consolidated Resources Healthcare Fund I, LP, a limited partnership, doing business as Alderwood Manor; Hallmark Manor; and Life Care Center of Federal Way

Cascade Medical Investors LP, a limited partnership, doing business as Cascade Park Care Center; Islands Convalescent Center; Kah Tai Care Center; Lake Vue Gardens Care Center; Port Orchard Care Center; and Marysville Care Center

Burien Medical Investors LP, a limited partnership, doing business as Life Care Center of Burien

Mount Vernon Medical Investors LP, a limited partnership, doing business as Life Care Center of Mount Vernon

Valley Terrace Investors LP, a limited partnership, doing business as Life Care Center of Puyallup

Skagit Valley Medical Investors LP, a limited partnership, doing business as Life Care Center of Skagit Valley

West Seattle Medical Investors LP, a limited partnership, doing business as Life Care Center of West Seattle

Ocean View Medical Investors LP, a limited partnership, doing business as Ocean View Convalescent Center

Gig Harbor Medical Investors LP, a limited partnership, doing business as Cottesmore of Life Care

Evangelical Lutheran Good Samaritan Society, Inc., a North Dakota non-profit corporation, doing business as Fairfield Good Samaritan Center; Spokane Valley Good Samaritan Village; and Stafholt Good Samaritan

Fort Vancouver Convalescent Center, LLC, a Washington limited liability company

American Baptist Homes of the West, a California non-profit corporation, doing business as Judson Park Health Center

Ridgemont Terrace, Inc., a Washington corporation

Hyatt Family Facilities, LLC, a Washington limited liability company, doing business as Landmark Care Center

RCW 74.46.431

Nursing facility medicaid payment rate allocations — Components — Minimum wage — Rules.

*** CHANGE IN 2010 *** (SEE 6872-S.SL) ***

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

(2) Component rate allocations in therapy care, support services, variable return, operations, property, and financing allowance for essential community providers as defined in this chapter shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities other than essential community providers, effective July 1, 2001, component rate allocations in direct care, therapy care, support services, and variable return shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds. For all facilities other than essential community providers, effective July 1, 2002, the component rate allocations in operations, property, and financing allowance shall be based upon a minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, effective July 1, 2006, the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

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

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, direct care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2006, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, direct care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. Effective July 1, 2009, the direct care component rate allocation shall be rebased biennially, and thereafter for each odd-numbered year beginning July 1st, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

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

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

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

(e) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six

months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2005, therapy care component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, therapy care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, therapy care component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the therapy care component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Therapy care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the therapy care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the therapy care component rate allocation established in accordance with this chapter.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2005, support services component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, support services component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, support services component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the support services component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Support services component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the support services component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the support services component rate allocation established in accordance with this chapter.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2006, operations component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, operations component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, operations component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the operations component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose operations component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).

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

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

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

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

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

(13) Effective July 1, 2001, medicaid rates shall continue to be revised downward in all components, in accordance with department rules, for facilities converting banked beds to active service under chapter 70.38 RCW, by using the facility's increased licensed bed capacity to recalculate minimum occupancy for rate setting. However, for facilities other than essential community providers which bank beds under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be revised upward, in accordance with department rules, in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting, but no upward revision shall be made to operations, property, or financing allowance component rates. The direct care component rate allocation shall be adjusted, without using the minimum occupancy assumption, for facilities that convert banked beds to active service, under chapter 70.38 RCW, beginning on July 1, 2006. Effective July 1, 2007, component rate allocations for direct care shall be based on actual patient days regardless of whether a facility has converted banked beds to active service.

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

[2009 c 570 § 1; 2008 c 263 § 2; 2007 c 508 § 2; 2006 c 258 § 2; 2005 c 518 § 944; 2004 c 276 § 913; 2001 1st sp.s. c 8 § 5; 1999 c 353 § 4; 1998 c 322 § 19.]

Notes:

Effective date -- 2009 c 570: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 19, 2009]." [2009 c 570 § 3.]

Effective date -- 2007 c 508: See note following RCW 74.46.410.

Effective date -- 2006 c 258: See note following RCW 74.46.020.

Severability -- Effective date -- 2005 c 518: See notes following RCW 28A.500.030.

Severability -- Effective date -- 2004 c 276: See notes following RCW 43.330.167.

Severability -- Effective dates -- 2001 1st sp.s. c 8: See notes following RCW 74.46.020.

Effective dates -- 1999 c 353: See note following RCW 74.46.020.

RCW 74.46.496
Case mix weights — Determination — Revisions.

*** CHANGE IN 2010 *** (SEE 6872-S.SL) ***

(1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) The case mix weights shall be based on the average minutes per registered nurse, licensed practical nurse, and certified nurse aide, for each case mix group, and using the health care financing administration of the United States department of health and human services 1995 nursing facility staff time measurement study stemming from its multistate nursing home case mix and quality demonstration project. Those minutes shall be weighted by statewide ratios of registered nurse to certified nurse aide, and licensed practical nurse to certified nurse aide, wages, including salaries and benefits, which shall be based on 1995 cost report data for this state.

(3) The case mix weights shall be determined as follows:

(a) Set the certified nurse aide wage weight at 1.000 and calculate wage weights for registered nurse and licensed practical nurse average wages by dividing the certified nurse aide average wage into the registered nurse average wage and licensed practical nurse average wage;

(b) Calculate the total weighted minutes for each case mix group in the resource utilization group III classification system by multiplying the wage weight for each worker classification by the average number of minutes that classification of worker spends caring for a resident in that resource utilization group III classification group, and summing the products;

(c) Assign a case mix weight of 1.000 to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

(5) Case mix weights shall be revised when direct care component rates are cost-rebased as provided in RCW 74.46.431 (4).

[2006 c 258 § 4; 1998 c 322 § 23.]

Notes:

Effective date -- 2006 c 258: See note following RCW 74.46.020.

RCW 74.46.501

Average case mix indexes determined quarterly — Facility average case mix index — Medicaid average case mix index.

*** CHANGE IN 2010 *** (SEE 6872-S.SL) ***

(1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question based on the resident assessment instrument completed by the facility and the requirements and limitations for the instrument's completion and transmission (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

(b) The facility average case mix index shall exclude all default cases as defined in this chapter. However, the medicaid average case mix index shall include all default cases.

(3) Both the facility average and the medicaid average case mix indexes shall be determined by multiplying the case mix weight of each resident, or each medicaid resident, as applicable, by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification or group, and then averaging.

(4)(a) In determining the number of days a resident is classified into a particular case mix group, the department shall determine a start date for calculating case mix grouping periods as follows:

(i) If a resident's initial assessment for a first stay or a return stay in the nursing facility is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the later of either the first day of the quarter or the resident's facility admission or readmission date;

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the date the assessment is completed;

(iii) If a resident's significant change, quarterly, or annual assessment is not timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the due date for the assessment.

(b) If state or federal rules require more frequent assessment, the same principles for determining the start date of a resident's classification in a particular case mix group set forth in subsection (4)(a) of this section shall apply.

(c) In calculating the number of days a resident is classified into a particular case mix group, the department shall determine an end date for calculating case mix grouping periods as follows:

(i) If a resident is discharged before the end of the applicable quarter, the end date shall be the day before discharge;

(ii) If a resident is not discharged before the end of the applicable quarter, the end date shall be the last day of the quarter;

(iii) If a new assessment is due for a resident or a new assessment is completed and transmitted to the department, the end date of the previous assessment shall be the earlier of either the day before the assessment is due or the day before the assessment is completed by the nursing facility.

(5) The cutoff date for the department to use resident assessment data, for the purposes of calculating both the facility average and the medicaid average case mix indexes, and for establishing and updating a facility's direct care component rate, shall be one month and one day after the end of the quarter for which the resident assessment data applies.

(6) A threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the ceiling, floor, and price. For direct care component rate allocations established on and after July 1, 2006, the threshold of ninety percent shall be used to determine the case mix index each quarter and to determine which facilities' costs per case mix unit are included in determining the ceiling and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing a facility's count of residents being assessed by the average census for the facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department

shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes.

(i) For October 1, 1998, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1997.

(ii) For July 1, 2001, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1999.

(iii) Beginning on July 1, 2006, when establishing the direct care component rates, the department shall use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in RCW 74.46.431.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, October 1, 1998, through December 31, 1998, direct care component rates shall utilize case mix averages from the April 1, 1998, through June 30, 1998, calendar quarter, and so forth.

[2006 c 258 § 5; 2001 1st sp.s. c 8 § 9; 1998 c 322 § 24.]

Notes:

Effective date -- 2006 c 258: See note following RCW 74.46.020.

Severability -- Effective dates -- 2001 1st sp.s. c 8: See notes following RCW 74.46.020.

**STATE OF WASHINGTON
 DSHS/AGING AND DISABILITY SERVICES ADMINISTRATION
 RATE COMPUTATION WORKSHEET
 JULY 2007 RATE SETTING**

NONESSENTIAL
 COMMUNITY
 PROVIDER

FACILITY
 NAME: ALDERWOOD MANOR
 ADDRESS:
 NUMBER: 4111027

TH & SS Costs from:
 REPORT PERIOD BEGINNING: 1/1/2005
 REPORT PERIOD ENDING: 12/31/2005
 DC & OP Costs from:
 REPORT PERIOD BEGINNING: 1/1/2005
 REPORT PERIOD ENDING: 12/31/2005
 PR & FA Costs From:
 REPORT PERIOD BEGINNING: 1/1/2006
 REPORT PERIOD ENDING: 12/31/2006

SECTION I - PATIENT DAY STATISTICS AND INFLATION FACTOR

ITEM 1	2005 TOTAL ADJUSTED PATIENT DAYS FROM SCHEDULE N	29730
ITEM 2	2005 TOTAL ADJUSTED MEDICAID PATIENT DAYS FROM SCHEDULE N	15697
ITEM 3	2005 REPORTED LICENSED BEDS	85
ITEM 4	2005 REASON CODE 22 ADJUSTMENTS TO REPORTED LICENSED BEDS	0
ITEM 5	2005 ADJUSTED LICENSED BED SIZE (ITEM 3 + ITEM 4)	85
ITEM 6	2005 TOTAL ADJUSTED PATIENT DAYS FROM SCHEDULE N	29730
ITEM 7	2005 TOTAL ADJUSTED MEDICAID PATIENT DAYS FROM SCHEDULE N	15697
ITEM 8	2005 REPORTED LICENSED BEDS	85
ITEM 9	2005 REASON CODE 22 ADJUSTMENTS TO REPORTED LICENSED BEDS	0
ITEM 10	2005 ADJUSTED LICENSED BED SIZE (ITEM 8 + ITEM 9)	85
ITEM 11	NEW BED SIZE FOR ALL FACILITIES IN THERAPY CARE and SUPPORT SERVICES	0
ITEM 12	NEW BED SIZE FOR NONESSENTIAL COMMUNITY PROVIDERS (Based on licensed beds as of May 25, 2001 or bed unbanking after May 25, 2001) PR and FA Only	0
ITEM 13	2005 DAYS IN REPORT PERIOD FOR THERAPY AND SUPPORT SERVICES	365
ITEM 14	2005 PATIENT DAYS AT 85% OCCUPANCY (ITEM 5 * ITEM 13 * 0.85)	26371
ITEM 15	2005 PATIENT DAYS USED FOR RATE SETTING IN THERAPY and SUPPORT SERVICES (Greater of Item 1 or Item 14)	29730
ITEM 16	[REDACTED]	
ITEM 16a	NEW BED SIZE FOR FACILITIES IN OPERATIONS	0
ITEM 17	2005 DAYS IN REPORT PERIOD for DIRECT CARE and OPERATIONS	365
ITEM 18	2005 COST REPORT OCCUPANCY PERCENTAGE FOR CALCULATION OF DAYS FOR NEW BED SIZE IN DIRECT CARE	96%
ITEM 19	[REDACTED]	
ITEM 20	2005 PATIENT DAYS AT 85% OR 90% OCCUPANCY FOR OPERATIONS (ESSENTIAL COMMUNITY PROVIDERS AT 85% (IF ITEM 16a>0, ITEM 16a * ITEM 17 * 0.85, ELSE ITEM 10 * ITEM 17 * 0.85) NONESSENTIAL COMMUNITY PROVIDERS AT 90%, (IF ITEM 16>0, ITEM 16 * ITEM 17 * 0.90, ELSE ITEM 10 * ITEM 17 * 0.90)	27923
ITEM 21	2006 TOTAL ADJUSTED PATIENT DAYS FROM SCHEDULE N	28656
ITEM 22	2006 TOTAL ADJUSTED MEDICAID PATIENT DAYS FROM SCHEDULE N	15770
ITEM 23	2006 REPORTED LICENSED BEDS	85
ITEM 24	2006 REASON CODE 22 ADJUSTMENTS TO REPORTED LICENSED BEDS	0
ITEM 25	2006 ADJUSTED LICENSED BED SIZE For Essential Community Providers (ITEM 23 + ITEM 24) For Nonessential Community Providers (BED SIZE as of May 25, 2001)	85
ITEM 26	NEW BED SIZE (If Licensed Bed Size has changed on or after May 25, 2001) (ONLY Essential Community Providers and All Facilities Unbanking Beds)	0
ITEM 27	2006 DAYS IN REPORT PERIOD	365
ITEM 28	2006 PATIENT DAYS AT 85% OCCUPANCY (ITEM 25 * ITEM 27 * 0.85) Essential Community Providers	0
ITEM 29	2006 PATIENT DAYS AT 90% OCCUPANCY ((ITEM 25 as of May 25, 2001) * ITEM 27 * 0.90) Based on Licensed Beds as of May 25, 2001 for Nonessential Community Providers	27923
ITEM 30	2006 PATIENT DAYS USED FOR PROPERTY & FINANCING ALLOWANCE Essential Community Provider (GREATER OF ITEM 21 OR ITEM 28) for Nonessential Community Provider (GREATER OF ITEM 21 OR ITEM 29) (IF BED CHANGE FOR ESSENTIAL COMMUNITY PROVIDERS OR BED UNBANKING FOR NONESSENTIAL COMMUNITY PROVIDERS SEE ITEM 34)	28656
ITEM 31	2005 PATIENT DAYS FOR THERAPY CARE AND SUPPORT SERVICES FOR CHANGES IN LICENSED BEDS (IF ITEM 11 > 0, THEN Greater of ITEM 1 or (ITEM 11 * ITEM 13 * 0.85), ELSE Greater of ITEM 1 or (ITEM 5 * ITEM 13 * 0.85))	0
ITEM 32	2005 PATIENT DAYS FOR DIRECT CARE (ITEM 6)	29730
ITEM 33	2005 PATIENT DAYS FOR OPERATIONS (Greater of ITEM 6 or ITEM 20)	29730
ITEM 34	2006 PATIENT DAYS FOR PROPERTY & FINANCING ALLOWANCE FOR CHANGES IN BEDS (After May 25, 2001 for Essential Community Providers and All Facilities Unbanking Beds) (For Essential Community Providers (If ITEM 26 > ITEM 25, then Greater of ITEM 21 or (ITEM 26 * ITEM 27 * 0.85) (If ITEM 26 < ITEM 25, and ITEM 30 = ITEM 21, then ITEM 30) (If ITEM 26 < ITEM 25 and ITEM 30 = ITEM 29 and ITEM 21 >= (ITEM 26 * ITEM 27 * 0.85), then ITEM 21)) If (ITEM 26 < ITEM 25 and ITEM 30 = ITEM 29 and ITEM 21 < (ITEM 26 * ITEM 27 * 0.85), then (ITEM 26 * ITEM 27 * 0.85)) For Nonessential Community Providers that Unbank Beds (If ITEM 26 > ITEM 25, then Greater of ITEM 21 or (ITEM 26 * ITEM 27 * 0.90) (If ITEM 26 < ITEM 25, then ITEM 30)	0

000562

SECTION I - PATIENT DAY STATISTICS AND INFLATION FACTOR (Continued)

ITEM 35	2005 ANNUALIZED PATIENT DAYS for FINANCING ALLOWANCE and LICENSE FEE ADD-ON ((365 / ITEM 27) * ITEM 30 or (ITEM 34 for Essential Community Providers and All Facilities Unbanking Beds))	28656
ITEM 36	VENDOR RATE INCREASE FOR FISCAL YEAR 08	1.0320
ITEM 37	VENDOR RATE INCREASE, ANNUALIZED (Item 36 Annualized)	1.0320
ITEM 38	FACILITY AVERAGE CASE MIX INDEX (All Four Quarters in 2005)	2.046
ITEM 39	MEDICAID AVERAGE CASE MIX INDEX (First Quarter 2007)	1.976
ITEM 40	IS THIS FACILITY IN A "Urban" or "Non-Urban" COUNTY? (1, 2 = Urban OR 3 = Non-Urban) for TH and SS	2
ITEM 40a	IS THIS FACILITY IN A "High Labor-Cost", "Urban" or "Non-Urban" COUNTY? (1, 2 OR 3) for DC and OP	2

SECTION II - DIRECT CARE COMPONENT**PART A: COST PER CASE MIX UNIT**

ITEM 41	2005 REPORTED DIRECT CARE COSTS (SCHEDULE G, COL. 5, LINE 112)	2,459,830
ITEM 42	DIRECT CARE EXAMINATION ADJUSTMENTS	(2,916)
ITEM 43	ADJUSTED DIRECT CARE COSTS (ITEM 41 - ITEM 42)	2,456,914
ITEM 44	ADJUSTED DIRECT CARE COST PPD (ITEM 43 / ITEM 32)	82.64
ITEM 45	COST PER CASE MIX UNIT (ITEM 44 / ITEM 38)	40.39

PART B: COST PER CASE MIX UNIT (112% CEILING RCW 74.46.506/ESSB 6158)

ITEM 46	COST PER CASE MIX UNIT (ITEM 45)	40.39
ITEM 47	"High Labor-Cost", "Urban", or "Non-Urban" PEER GROUP CEILING (112% OF MEDIAN)	48.16
ITEM 48	COST PER CASE MIX UNIT AFTER CORRIDOR (IF ITEM 46 > ITEM 47, then ITEM 47, else ITEM 46)	40.39
ITEM 49	CASE MIX DIRECT CARE RATE PPD (ITEM 48 * ITEM 39)	79.81

PART C: DIRECT CARE RATE COMPONENT

ITEM 50	CASE MIX DIRECT CARE RATE PPD ADJUSTED FOR VENDOR RATE INCREASES (ITEM 49 * 1.032 annualized for FY 08)	82.36
ITEM 51	INFLATED DIRECT CARE RATE PPD (ITEM 50)	82.36

000563

Appendix E
Page 2 of 7

EXHIBIT 1
PAGE 2 OF 7

SECTION III - THERAPY CARE COMPONENT

ITEM 52	2005 REPORTED THERAPY COSTS (SCHEDULE G, COL. 5, LINE 113)	60,997
ITEM 53	EXAMINATION ADJUSTMENTS (INCLUDES APPLICATION OF LIMITS BY THERAPY TYPE)	(1,016)
ITEM 54	ADJUSTED THERAPY COSTS (ITEM 52 + ITEM 53)	59,981
ITEM 55	ADJUSTED THERAPY COSTS PPD (If ITEM 11 = 0, then ITEM 54 / ITEM 15) (If ITEM 11 > 0, then ITEM 54 / ITEM 31)	2.02
ITEM 56	THERAPY CARE RATE PPD ADJUSTED FOR VENDOR RATE INCREASES (ITEM 55 * 1.032 annualized for FY 08)	2.08

SECTION IV - SUPPORT SERVICES COMPONENT

ITEM 57	2005 REPORTED SUPPORT SERVICE COST (SCHEDULE G, COL. 5, LINE 145)	619,247
ITEM 58	EXAMINATION ADJUSTMENTS TO SUPPORT SERVICES COMPONENT	(261)
ITEM 59	ADJUSTED SUPPORT SERVICES COST (ITEM 57 + ITEM 58)	618,986
ITEM 60	ADJUSTED SUPPORT SERVICES COST PPD (If ITEM 11 = 0, then ITEM 59 / ITEM 15) (If ITEM 11 > 0, then ITEM 59 / ITEM 31)	20.82
ITEM 61	"Urban" OR "Non-Urban" PEER GROUP ADJUSTED SUPPORT SERVICES COST LID PPD	23.55
ITEM 62	ADJUSTED SUPPORT SERVICES COST PPD (LESSER OF ITEM 60 OR ITEM 61)	20.82
ITEM 63	SUPPORT SERVICES RATE PPD ADJUSTED FOR VENDOR RATE INCREASES (ITEM 62 * 1.032 annualized for FY 08)	21.49

SECTION V - OPERATIONS COMPONENT

ITEM 64	2005 REPORTED OPERATIONS COST (SCH G, COL. 5, LINE 218)	1,228,461
ITEM 65	EXAMINATION ADJUSTMENTS TO OPERATIONS COMPONENT	3,999
ITEM 66	REMOVE 2005 QUALITY MAINTENANCE FEES PAID (SCHEDULE G, COL 5, LINE 192, ACCOUNT 5430)	(120,873)
ITEM 67	ADJUSTED OPERATIONS COST (ITEM 64 + ITEM 65 + ITEM 66)	1,111,587
ITEM 68	ADJUSTED OPERATIONS COST PPD (ITEM 67/ITEM 33)	37.39
ITEM 69	"Urban" OR "Non-Urban" PEER GROUP ADJUSTED OPERATIONS COST LID PPD	32.71
ITEM 70	ADJUSTED OPERATIONS COST PPD (LESSER OF ITEM 68 OR ITEM 69)	32.71
ITEM 71	OPERATIONS RATE PPD ADJUSTED FOR VENDOR RATE INCREASES (ITEM 70 * 1.032 annualized for FY 08)	33.76

000564

SECTION VI - PROPERTY COMPONENT

ITEM 72	2006 REPORTED PROPERTY (SCHEDULE G, COL. 5, LINE 237)	222,194
ITEM 73	2006 EXAMINATION ADJUSTMENTS	(10,093)
ITEM 74	2006 ADJUSTED DEPRECIATION (ITEM 72 + ITEM 73)	212,101
	2006 ADJUSTED DEPRECIATION PPD	7.40
	(IF ITEM 26 = 0, THEN ITEM 74 / ITEM 30) (IF ITEM 26 > 0 & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS, THEN ITEM 74 / ITEM 34)	
ITEM 75	PROPERTY RATE PPD (ITEM 75)	7.40
ITEM 77	CURRENT FUNDING FOR CAPITAL IMPROVEMENTS NOT INCLUDED IN REASON CODE 27	0
	CURRENT FUNDING FOR CAPITAL IMPROVEMENTS PPD	0.00
	(IF ITEM 26 = 0, THEN ITEM 77 / ITEM 30) (IF ITEM 26 > 0 & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS, THEN ITEM 77 / ITEM 34 (ANNUALIZED))	
ITEM 78	PROPERTY RATE PPD PLUS CURRENT FUNDING PPD (ITEM 76 + ITEM 78)	7.40

SECTION VII - FINANCING ALLOWANCE COMPONENT

	2006 REPORTED NET BOOK VALUE OF ALLOWABLE ASSETS	2,516,373
ITEM 80	(SCHEDULE B, COL. 6, LINE 35)	
ITEM 81	2006 EXAMINATION ADJUSTMENTS TO NET BOOK VALUE	10,561
ITEM 82	ADJUSTED 2006 NET BOOK VALUE OF ALLOWABLE ASSETS (ITEM 80 + ITEM 81)	2,526,934
	ADJUSTED 2006 NET BOOK VALUE OF ALLOWABLE ASSETS FOR ASSETS PURCHASED ON OR AFTER MAY 17, 1999 (REASON CODE 17 EXAMINATION ADJUSTMENT) ENGROSSED 2ND SUBSTITUTE HOUSE BILL 1484	259,065
ITEM 83		
ITEM 84	ADJUSTED 2006 NBV OF ALLOWABLE ASSETS PURCHASED BEFORE MAY 17, 1999 (ITEM 82 - ITEM 83)	2,267,869
	FINANCING ALLOWANCE PPD FOR ASSETS PURCHASED BEFORE MAY 17, 1999	7.91
	(IF ITEM 26 = 0, THEN ((ITEM 84) * 0.10) / ITEM 35) (IF ITEM 26 > 0 & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS, THEN ((ITEM 84) * 0.10) / ITEM 34 (ANNUALIZED))	
ITEM 85	FINANCING ALLOWANCE PPD FOR ASSETS PURCHASED ON OR AFTER MAY 17, 1999	0.77
	(IF ITEM 26 = 0, THEN (ITEM 83 * 0.085) / ITEM 35) (IF ITEM 26 > 0, & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS THEN (ITEM 83 * 0.085) / ITEM 34 (ANNUALIZED))	
ITEM 86		
ITEM 87	CURRENT FUNDING - NET BOOK VALUE ASSOCIATED WITH PURCHASES ON OR AFTER MAY 17, 1999	0
	FINANCING ALLOWANCE FOR CURRENT FUNDED NBV PURCHASED ON OR AFTER MAY 17, 1999	0.00
	(IF ITEM 26=0, THEN (ITEM 87 * 0.085) / ITEM 35) (IF ITEM 26>0 & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS, THEN (ITEM 87 * 0.085) / ITEM 34 (ANNUALIZED))	
ITEM 88	FINANCING ALLOWANCE PLUS CURRENT FUNDED FINANCING ALLOWANCE	8.68
ITEM 89	(ITEM 85 + ITEM 86 + ITEM 88)	

SECTION VIII - VARIABLE RETURN COMPONENT

ITEM 90	JUNE 30, 2006 VARIABLE RETURN RATE (EHB 2716)	2.54
ITEM 91	NEWLY MEDICAID IN 2006 or After (SUM OF DC, TH, SS AND OP RATES PPD (ITEM 51 + ITEM 56 + ITEM 63 + ITEM 71))	0.00
ITEM 92	NEWLY MEDICAID IN 2006 or after (VARIABLE RETURN RATIO (1% TO 4%) (JULY 1, 2001 REBASE))	0%
ITEM 93	VARIABLE RETURN RATE PPD (ITEM 90, OR IF NEWLY MEDICAID (ITEM 91 * ITEM 92))	2.54
ITEM 94	FINANCING ALLOWANCE PLUS VARIABLE RETURN PPD (ITEM 89 + ITEM 93)	11.22

000565

**SECTION IX - ALTERNATIVE FINANCING ALLOWANCE
(FOR GRANDFATHERED LEASES ONLY)**

ITEM 95	GRANDFATHERED LEASE FLAG (IF GRANDFATHERED, THEN "1", OTHERWISE "0")	0
ITEM 96	2005 REPORTED DEPRECIATION, INTEREST AND LEASE PAYMENT (SUPPLEMENTAL SCHEDULE I-4, COL 5, LINE 18)	0
ITEM 97	2005 EXAMINATION ADJUSTMENTS TO SCHEDULE I-4	0
EM 98	2005 EXAMINED DEPRECIATION, INTEREST AND LEASE PAYMENT (ITEM 96 + ITEM 97)	0
	EXAMINED COST PPD	0.00
	(IF ITEM 26 = 0, THEN ITEM 98 / ITEM 35)	
ITEM 99	(IF ITEM 26 > 0, THEN ITEM 98 / ITEM 34 (ANNUALIZED))	
ITEM 100	EXAMINED COST PPD MINUS PROPERTY RATE (ITEM 99 - ITEM 79)	0.00

**IF ITEM 100 IS LESS THAN OR EQUAL TO ITEM 94, THEN ITEM 94 APPLIES
IF ITEM 100 IS GREATER THAN ITEM 94, THE ALTERNATIVE FINANCING ALLOWANCE APPLIES, AS
COMPUTED BELOW (ITEM 101 THROUGH ITEM 113)**

ITEM 101	2005 REPORTED TOTAL ASSETS FOR ALTERNATIVE FINANCING ALLOWANCE (SUPPLEMENTAL SCHEDULE I-3, COL 7, LINE 18)	0
ITEM 102	2005 EXAMINATION ADJUSTMENTS TO SCHEDULE I-3	0
ITEM 103	2005 EXAMINED ASSETS FOR ALTERNATIVE FINANCING ALLOWANCE (ITEM 101 + ITEM 102)	0
ITEM 104	2005 REPORTED ACCUMULATED DEPRECIATION ON ASSETS FOR ALTERNATIVE FINANCING ALLOWANCE (SUPPLEMENTAL SCHEDULE I-5, COL 14, LINE 11)	0
ITEM 105	EXAMINATION ADJUSTMENTS TO I-5	0
ITEM 106	2005 EXAMINED ACCUMULATED DEPRECIATION	0
ITEM 107	2005 BOOK VALUE OF ASSETS FOR ALTERNATIVE FINANCING ALLOWANCE (ITEM 103 - ITEM 106)	0
ITEM 108	ALTERNATIVE NET INVESTED FUNDS (ITEM 108 - ITEM 110) FOR ALTERNATIVE FINANCING ALLOWANCE FOR ASSETS PURCHASED BEFORE MAY 17, 1999, ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1484	0
ITEM 109	ALTERNATIVE NET INVESTED FUNDS FOR ALTERNATIVE FINANCING ALLOWANCE FOR ASSETS PURCHASED AFTER MAY 17, 1999, ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1484 (REASON CODE 17 EXAMINATION ADJUSTMENT)	0
ITEM 110	ALTERNATIVE FINANCING ALLOWANCE PPD FOR ASSETS PURCHASED BEFORE MAY 17, 1999 (IF ITEM 26 = 0, THEN (ITEM 108 * 0.10) / ITEM 35) (IF ITEM 26 > 0, THEN (ITEM 108 * 0.10) / ITEM 34 (ANNUALIZED))	0.00
ITEM 111	ALTERNATIVE FINANCING ALLOWANCE PPD FOR ASSETS PURCHASED ON OR AFTER MAY 17, 1999 (IF ITEM 26 = 0, THEN (ITEM 109 * 0.085) / ITEM 35) (IF ITEM 26 > 0, THEN (ITEM 109 * 0.085) / ITEM 34 (ANNUALIZED))	0.00
ITEM 112	ALTERNATIVE FINANCING ALLOWANCE PLUS VARIABLE RETURN (ITEM 93 + ITEM 110 + ITEM 111)	0.00
EM 113	ALTERNATIVE FINANCING ALLOWANCE PLUS VARIABLE RETURN PPD (LESSER OF ITEM 100 OR ITEM 112)	0.00

SECTION X - RATE ADD-ON FOR CURRENT FUNDING

ITEM 114	CURRENT FUNDING FOR ADMINISTRATOR-IN-TRAINING PPD	0.00
ITEM 115	CURRENT FUNDING FOR PROPERTY TAX INCREASE PPD (TAX INCREASE GRANTED AFTER 7/1/06) * 1.032 for FY. 08)	0.00
ITEM 116	CURRENT FUNDING FOR PROPERTY TAX INCREASE PPD (TAX INCREASE GRANTED AFTER 7/1/07)	0.00
ITEM 117	TOTAL RATE ADD-ON FOR CURRENT FUNDED OPERATION COMPONENT (ITEM 114 + ITEM 115 + ITEM 116)	0.00

SECTION XI - NURSING HOME LOW-WAGE WORKER/LICENSE FEE ADD-ON

ITEM 118	DIRECT CARE LOW WAGE WORKER - (.6% OF DIRECT CARE RATE COMPONENT)	0.49
----------	---	------

000566

SECTION XII - CALCULATED REBASED RATE BEFORE BUDGET DIAL

ITEM 119	DIRECT CARE COMPONENT (ITEM 51 + ITEM 118)	82.85
ITEM 120	THERAPY CARE COMPONENT (ITEM 56)	2.08
ITEM 121	SUPPORT SERVICES COMPONENT (ITEM 63)	21.49
ITEM 122	OPERATIONS COMPONENT (ITEM 71 + ITEM 117)	33.76
ITEM 123	PROPERTY COMPONENT (ITEM 79)	7.40
ITEM 124	FINANCING ALLOWANCE COMPONENT (ITEM 89 OR (ITEM 113 less ITEM 93 (if Grandfathered)))	8.68
ITEM 125	VARIABLE RETURN COMPONENT (ITEM 93)	2.54
ITEM 126	SUBTOTAL MEDICAID PROSPECTIVE RATE BEFORE BUDGET DIAL	<u>158.80</u>

SECTION XIII - HOLD HARMLESS PROVISION/COMPARISON (ESSB 6158)

ITEM 127	PRIOR FISCAL YEAR (FY 07) QUALITY MAINTENANCE FEE ADD-ON (YES,NO)	YES
ITEM 128	6/30/07 DIRECT CARE RATE	81.79
ITEM 129	6/30/07 THERAPY RATE	0.48
ITEM 130	6/30/07 SUPPORT SERVICE RATE	21.30
ITEM 131	6/30/07 OPERATION RATE	36.96
ITEM 132	6/30/07 NON-CAPITAL RATE (ITEM 128 + ITEM 129 + ITEM 130 + ITEM 131 - \$5.25 IF ITEM 127 = "YES")	135.28
ITEM 133	REBASED NON-CAPITAL RATE (ITEM 119 + ITEM 120 + ITEM 121 + ITEM 122)	140.18
ITEM 134	HELD HARMLESS (IF ITEM 132 IS GREATER THAN ITEM 133, THEN "YES", ELSE "NO")	NO

SECTION XIV - CALCULATED RATE AFTER HOLD HARMLESS PROVISION AND BEFORE BUDGET DIAL

ITEM 135	DIRECT CARE COMPONENT (IF ITEM 134 = "YES", ITEM 128 *1.032, ELSE ITEM 119)	82.85
ITEM 136	THERAPY CARE COMPONENT (IF ITEM 134 = "YES", ITEM 129 *1.032, ELSE ITEM 120)	2.08
ITEM 137	SUPPORT SERVICES COMPONENT (IF ITEM 134 = "YES", ITEM 130 *1.032, ELSE ITEM 121)	21.49
ITEM 138	OPERATIONS COMPONENT (IF ITEM 134 = "YES", ITEM 131 *1.032, ELSE ITEM 122)	33.76
ITEM 139	PROPERTY COMPONENT (ITEM 123)	7.40
ITEM 140	FINANCING ALLOWANCE COMPONENT (ITEM 124)	8.68
ITEM 141	VARIABLE RETURN COMPONENT (ITEM 125)	2.54
ITEM 142	SUBTOTAL MEDICAID PROSPECTIVE RATE BEFORE BUDGET DIAL	<u>158.80</u>

SECTION XV - BUDGET DIAL

ITEM 143	CALCULATED RATE BEFORE BUDGET DIAL (ITEM 142)	158.80
ITEM 144	BUDGET DIAL ADJUSTMENT	0.00

SECTION XV - FINAL CALCULATED RATE AFTER BUDGET DIAL

ITEM 145	DIRECT CARE COMPONENT (ITEM 135 MINUS (ITEM 144 ALLOCATED))	82.85
ITEM 146	THERAPY CARE COMPONENT (ITEM 136 MINUS (ITEM 144 ALLOCATED))	2.08
ITEM 147	SUPPORT SERVICES COMPONENT (ITEM 137 MINUS (ITEM 144 ALLOCATED))	21.49
ITEM 148	OPERATIONS COMPONENT (ITEM 138 MINUS (ITEM 144 ALLOCATED))	33.76
ITEM 149	PROPERTY COMPONENT (ITEM 139 MINUS (ITEM 144 ALLOCATED))	7.40
ITEM 150	FINANCING ALLOWANCE COMPONENT (ITEM 140 MINUS (ITEM 144 ALLOCATED))	8.68
ITEM 151	VARIABLE RETURN COMPONENT (ITEM 141 MINUS (ITEM 144 ALLOCATED))	2.54
ITEM 152	TOTAL MEDICAID PROSPECTIVE RATE AFTER BUDGET DIAL	<u>158.80</u>

000567

**STATE OF WASHINGTON
DSHS/AGING AND DISABILITY SERVICES ADMINISTRATION
NURSING FACILITY RATE NOTIFICATION**

THIS RATE IS IN EFFECT UNTIL NOTIFICATION OF RATE CHANGE

	RATE EFFECTIVE JULY 1, 2007
DC - DIRECT CARE COMPONENT	82.85
TC - THERAPY CARE COMPONENT	2.08
SS - SUPPORT SERVICES COMPONENT	21.49
OP - OPERATIONS COMPONENT	33.76
PR - PROPERTY COMPONENT	7.40
FA - FINANCING ALLOWANCE COMPONENT	8.68
VR - VARIABLE RETURN COMPONENT	2.54
TL - TOTAL	<hr/> 158.80

CONTACT THE OFFICE OF PROVIDER SERVICES AT 1-800-562-6188 FOR QUESTIONS REGARDING PAYMENTS OR RECOUPMENTS

FACILITY NUMBER:	4111027
NATIONAL PROVIDER IDENTIFIER	1245284835
LOCATION NUMBER	33200
PROCESS DATE:	9/23/2008

**ALDERWOOD MANOR
3600 EAST HARTSON AVENUE
SPOKANE, WA. 992020000**

000568

**Appendix E
Page 7 of 7**

EXHIBIT 1
PAGE 7 OF 7

FILED
COURT OF APPEALS

10 JUN 14 PM 12:27

STATE OF WASHINGTON

No. 40606-3-II

BY

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

LIFE CARE CENTERS OF AMERICA, INC., et al.,

Appellants

vs.

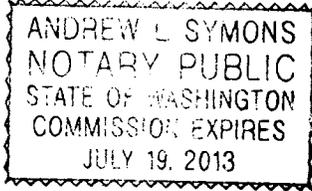
DEPARTMENT OF SOCIAL AND HEALTH SERVICES, STATE OF
WASHINGTON,

Respondent.

AFFIDAVIT OF SERVICE OF APPELLANTS' OPENING BRIEF

INSLEE, BEST, DOEZIE & RYDER, P.S.
John F. Sullivan, W.S.B.A. #15426
Attorneys for Appellants
777 - 108th Avenue N.E., Suite 1900
Bellevue, WA 98004
P.O. Box 90016
Bellevue, Washington 98009-9016
Telephone: 425-455-1234

SUBSCRIBED AND SWORN TO before me this 13th day
of July, 2010.



Andrew L. Symons
NAME: ANDREW L. SYMONS
(Print Name)
Notary Public in and for the
State of Washington
Commission Expires: 7-19-13