

NO. 40606-3-II

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

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

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,
STATE OF WASHINGTON,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

This case is a judicial review under the Washington Administrative Procedure Act of a final agency order in an adjudicative proceeding. Appellants, nursing facilities that provide care to both Medicaid residents and non-Medicaid residents, ask this Court to determine that the Department of Social and Health Services (Department) made an error of law in interpreting the Washington State nursing facility Medicaid payment system statutes. The Department followed the plain meaning of the relevant statutes, and it correctly applied the statutes as a unified whole that maintained the integrity of each statute. The Appellants cannot meet their burden in this judicial review to show an error of law.

This case involves an input in the formula used to calculate each Appellant facility's Medicaid payment rate. This input is called FACMI, which stands for "facility average case mix index." The Department requests that this Court adopt the same legal analysis as Thurston County Superior Court and conclude that "the inference urged by [Appellants] is impermissible" because "the language in [RCW 74.46]¹

¹ During the 2010 legislative session, there were substantial changes made to the nursing facility Medicaid payment system laws, Chapter 74.46 RCW. Laws of 2010, Chapter 34 (61st Leg., 1st Sp. Sess.). All citations in this brief are to the statutes in effect prior to the 2010 legislative session. If a statute cited in this brief was repealed in entirety by the 2010 legislation, it is referred to as "former." For the Court's convenience, copies

§.431(4)(a) and §.501(7)(b)(iii) is specific and directly on point regarding the use of 1999 adjusted cost report data in the FACMI formula for the rate calculation at issue here.” Clerk’s Papers (CP) 74. The Appellants’ argument that RCW 74.46.496(4) and (5) require otherwise, “is not a reasonable inference in light of the specific intent of the legislature expressed in the other two statutes.” *Id.*

The Department respectfully requests that this Court AFFIRM both the Superior Court’s Order and the Department’s Decision and Final Order. CP 76-82 (Superior Court’s Order and Opinion); Agency Record (AR) 1-19 (Department’s Decision and Final Order).

II. COUNTER-STATEMENT OF ISSUES

1. Under RCW 74.46.501(7)(b)(iii), calculation of the 2007 Medicaid payment rate for direct care “shall use an average of facility case mix indexes [FACMI] from the four calendar quarters occurring during the cost report period used” to calculate the rate allocations as specified in RCW 74.46.431(4)(a). RCW 74.46.431(4)(a) required the July 1, 2007, Medicaid payment rate for direct care to use cost report data from 2005. Did the Department act correctly in using the facility average case mix indexes (FACMI) occurring during the four calendar quarters of 2005 to set the July 1, 2007, Medicaid payment rate for direct care?

of the pre-2010 versions of the most cited statutes are attached to this brief as Appendices C-E.

2. Under RCW 74.46.431(4)(a), “data from 1999 will be used for July 1, 2001, through June 30, 2006.” In 2005, when the 2005 FACMI scores were calculated each quarter for each facility, did the Department correctly use wage ratio data from 1999 in calculating the FACMI scores?

III. COUNTER-STATEMENT OF THE CASE

A. General Overview: The Medicaid Rate For Nursing Facilities

The Department administers the cooperative federal-state Medicaid program in Washington State. As a part of this program, the Department compensates nursing facilities for services provided to Medicaid-eligible residents. The Legislature has set forth in law an intricate methodology by which legislative appropriations for Medicaid residents are to be allocated among nursing facilities. RCW 74.46.010. Under this methodology, the Department annually determines a Medicaid daily rate for each nursing facility for the upcoming fiscal year (July 1 through June 30). Chapter (Ch.) 74.46 RCW; *see also* Ch. 388-96 WAC. Each nursing facility has its own, facility-specific rate for the fiscal year. *E.g.*, RCW 74.46.431(1). For example, one nursing facility could receive \$156 per Medicaid resident per day, whereas a different nursing facility could receive \$161 per Medicaid resident per day. The rate for each fiscal year is named for the first day of that fiscal year—in

other words, the July 1, 2007, rate is the daily rate for each Medicaid resident in the facility from July 1, 2007, until June 30, 2008.

A facility's Medicaid daily rate is a combination of seven component rates, each of which corresponds to a category of costs that nursing facilities incur. RCW 74.46.431(1). Only one of these component rates—direct care—is at issue in this case.² Direct care refers to nursing services and supplies provided to nursing facility residents. RCW 74.46.020(17), (18).³ The direct care component of the Medicaid rate, like the overall rate, is also facility-specific; one nursing facility could receive \$77 per Medicaid resident per day for direct care, whereas another facility could receive \$82 per Medicaid resident per day for direct care. The direct care component of the Medicaid rate is referred to in this brief as either “Medicaid payment rate for direct care” or “direct care component rate.” These terms refer to the exact same thing: the portion of each facility's overall Medicaid rate that is for the direct care component of the rate.

² Other components include therapy, support services, operations, property, financing allowance, and variable return.

³ As mentioned in footnote 1, all citations in this brief are to the statutes in effect prior to the 2010 legislative session. The current definitions for direct care are at subsections (14) and (15).

B. The Medicaid Payment Rate For Direct Care

The Medicaid payment rate for direct care (calculated individually for each facility) considers the facility's costs and the complexity of care required by the facility's residents. To quantify the complexity of care required by the residents, the Department uses two numerical values: the FACMI (facility average case mix index) and the MACMI (Medicaid average case mix index). RCW 74.46.501(1)-(3); AR 8 (*Conclusion of Law 5*). The FACMI score is a numerical value associated with the intensity of care and services needed by all the residents at a facility for a particular calendar quarter—i.e., the residents' acuity level. *Id.* The MACMI score is a numerical value associated with the intensity of care and services needed by only the Medicaid residents at a facility for a particular calendar quarter—i.e., the Medicaid residents' acuity level. *See id.*

Generally, and as will be discussed in more detail below, the Medicaid payment rate for direct care is calculated for each facility with a formula that has three input factors: (1) the facility's costs; (2) the complexity of care required by all the facility's residents—the FACMI score; and (3) the complexity of care required by only the facility's Medicaid residents—the MACMI score. AR 3 (*Finding of Fact 3*). The only issue in this case is what FACMI score should have been inserted

into the formula for the Medicaid payment rate for the fiscal year starting July 1, 2007, and ending June 30, 2008. AR 19 (*Decision*).

1. Costs (And How Costs Relate To The Medicaid Payment Rate For Direct Care)

Every year, each Medicaid nursing facility submits a “cost report” to the Department that includes detailed data about the facility’s costs.⁴ *See generally* former RCW 74.46.030-.060. In establishing the Medicaid payment rate for each facility, the Department uses each facility’s prior costs to establish that facility’s current Medicaid rate. The Legislature establishes explicitly which prior year’s cost report should be used in each year’s rate. RCW 74.46.431(4)-(8). A cost report from a specific year often is used for more than one year’s rate. *Id.* Periodically, the Legislature requires the Department to use a more-updated year’s cost report in calculating the current year’s rate; this process is known as “rebasings” the rate. When a cost report is used for the first time in calculating a rate, that year’s rate is referred to as a “rebase year.” For example, if the 2003 cost reports were used for the first time in calculating the 2006 rate, then 2006 would be a “rebase year” and it would be said that rates were “rebased in 2006.”

⁴ The Department audits each facility’s annual cost report to ensure compliance with applicable rules to determine whether reported costs are “allowable” under the law. Former RCW 74.46.100. There is no dispute in this case about “actual” costs versus “allowable” costs and therefore, in an attempt to simplify, this brief does not distinguish between the two.

As relevant to this case, the Legislature required the Medicaid payment rate for direct care to be rebased in 2001, using 1999 cost report data; rebased in 2006, using 2003 cost report data; and then again rebased in 2007, using 2005 cost report data. RCW 74.46.431(4)(a). In other words, the statute required the use of the 1999 cost report data in setting the Medicaid payment rate for direct care for the July 1, 2001, 2002, 2003, 2004, and 2005 rates (July 1, 2001, through June 30, 2006). *Id.* For the July 1, 2006, Medicaid payment rate (July 1, 2006, through June 30, 2007), the statute required the use of the 2003 cost report data. *Id.* And for the July 1, 2007, Medicaid payment rate (July 1, 2007, through June 30, 2008), the statute required the use of the 2005 cost report data. *Id.* As a result of the long time period between rebasing from 2001 to 2006, the statute explicitly required that the cost report data from 1999 be used for a period of five years—from July 1, 2001, through June 30, 2006—even though newer cost reports were available. *Id.*

2. Complexity of Care: FACMI and MACMI (And How Complexity of Care Relates to the Medicaid Payment Rate For Direct Care)

In addition to costs, the complexity of the care required by each facility's residents is also relevant to the calculation of that facility's Medicaid payment rate for direct care. RCW 74.46.501(7); AR 3

(*Finding of Fact 3*); AR 7-8 (*Conclusions of Law 4 & 5*). To determine this, each resident is assessed and then assigned to one of 44 groups, based on the level and complexity of nursing care that the individual resident requires. RCW 74.46.485(1)(a); AR 7-8 (*Conclusion of Law 4*). The Department uses a “case mix” methodology, where a “case mix weight” is assigned to each of the 44 groups based on the average number of nursing minutes required by that group from Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides. RCW 74.46.496(2); AR 8 (*Conclusion of Law 6*). The Department is required to revise the case mix weights each time that rates are rebased. RCW 74.46.496(4), (5). Thus, as discussed above, because the Legislature required rates to be rebased in 2001, 2006, and 2007, the Department was required to revise the case mix weights in 2001, 2006, and 2007.

With each resident in the nursing facility assigned to a specific group (and therefore a specific case mix weight), the Department is able calculate a numeric value associated with the care needs of the residents in each nursing facility. RCW 74.46.501; AR 8 (*Conclusion of Law 5*). The Department calculates two average case mix indexes every quarter for each nursing facility: the FACMI (facility average case mix index)

and the MACMI (Medicaid average case mix index). RCW 74.46.501(1)-(3).

The FACMI score is a numerical value associated with the intensity of care and services needed by all the residents at a facility for a particular calendar quarter—i.e., the residents' acuity level. RCW 74.46.501(1)-(3); AR 8 (*Conclusion of Law 5*). The FACMI score is determined by multiplying the case mix weight of each resident by the number of days the resident was at each particular case mix group, and then averaging. RCW 74.46.501(3). The Department calculates a FACMI score for each nursing facility every calendar quarter—i.e., each facility will have a first-quarter 2005 FACMI score, a second-quarter 2005 FACMI score, a third-quarter 2005 FACMI score, a fourth-quarter 2005 FACMI score, etc. RCW 74.46.501(1). Thus, each quarterly FACMI score reflects the care needs of all the residents in the facility during that specific calendar quarter.

The MACMI score is a numerical value associated with the intensity of care and services needed by only the Medicaid residents at a facility for a particular calendar quarter—i.e., the Medicaid residents' acuity level. RCW 74.46.501(1)-(3); *see also* AR 8 (*Conclusion of Law 5*). The MACMI score is determined by multiplying the case mix weight of each Medicaid resident by the number of days that resident

was at each particular case mix group, and then averaging. RCW 74.46.501(3). The Department calculates a MACMI score for each nursing facility every calendar quarter. RCW 74.46.501(1). Each quarterly MACMI score reflects the care needs of only the Medicaid residents in the facility during that specific calendar quarter.

As mentioned above, the only issue in this case is what FACMI score should have been inserted into the formula for the Medicaid payment rate for the fiscal year starting July 1, 2007 and ending June 30, 2008. The crux of this issue lies in whether the Department was required to retroactively apply the updated 2007 case mix weights to the FACMI scores that had previously been calculated in 2005.

C. The Formula For Calculating the Medicaid Payment Rate For Direct Care

Generally, a nursing facility's Medicaid payment rate for direct care is calculated by taking the facility's costs (per patient per day), dividing that number by the care needs of all the residents at the facility (FACMI), and then multiplying that number by the care needs of only the Medicaid residents (MACMI). It is undisputed in this case that, in calculating the Medicaid payment rate for direct care for each Appellant facility's July 1, 2007 rate, the Department took each nursing facility's

costs⁵ from the 2005 cost reports, divided that number by an average of FACMI values calculated during the four quarters of 2005, and then multiplied that number by the first-quarter 2007 MACMI. AR 3-4 (*Findings of Fact 3 & 4*). In other words, the formula the Department used for setting each of the Appellant's July 1, 2007 Medicaid payment rates for direct care is as follows:

$$\begin{aligned} & \text{2007 Medicaid Payment Rate For Direct Care} = \\ & (\text{2005 Costs} \div \text{2005 FACMI}) \times \text{1st quarter 2007 MACMI} \end{aligned}$$

To tangibly observe how this formula works, one can review a few lines in the Rate Computation Worksheet for Alderwood Manor, provided as Appendix F. AR 562-568. Items 41 through 51 on the Worksheet—Section II “Direct Care Component”—show the calculation of the Medicaid payment rate for direct care for Alderwood Manor's July 1, 2007 rate. AR 563; Appendix F, p. 2. As seen in Item 44,⁶ Alderwood Manor's costs per patient per day from the 2005 cost report were \$82.64. In other words, Alderwood Manor spent \$82.64 for direct care for each resident in the facility each day during 2005. In Item 45, Alderwood Manor's costs were divided by the 2005 FACMI (the

⁵ This is each facility's allowable costs per patient per day.

⁶ Items 41 through 43 convert total 2005 direct care costs into allowable direct care costs per patient per day. This part of the calculation is not an issue in this case and, therefore, is not addressed for simplicity.

average of the care needs of all the residents in the facility during all four quarters of 2005). This is shown as the costs divided by the FACMI (Item 45 ÷ Item 38). In this case, Alderwood Manor's costs divided by FACMI equaled \$40.39, as shown in Item 45, 46, and 48.⁷ That number was then multiplied by the first-quarter 2007 MACMI (average of the care needs of the Medicaid residents in the facility during the first quarter of 2007) in Item 49, resulting in the Medicaid payment rate of \$79.81 per patient per day (Item 48 × Item 39). The basic formula (in the box above) uses this information to calculate the 2007 Medicaid payment rate for direct care as follows, with each line reflecting the same information:

- | |
|---|
| <ol style="list-style-type: none">1. 2007 Rate = (2005 Costs ÷ 2005 FACMI) × 1st quarter 2007 MACMI2. Item 49 = (Item 44 ÷ Item 38) × Item 393. \$79.81 = (\$82.64 ÷ 2.046) × 1.976 |
|---|

Then some rate add-ons, not relevant to this case, inflated the ultimate direct care component rate to \$82.85 per patient per day.⁸ AR 568.

⁷ The mention on the Worksheet of the High Labor Cost Corridor is not relevant to this case.

⁸ In Item 51, the rate was multiplied by an inflation factor set by the Legislature to reach the inflated Medicaid payment rate for direct care of \$82.36 per Medicaid patient per day. AR 563; Appendix F, p. 2. Then in Item 118, a low-wage worker add-on increased the rate by \$0.49 to an ultimate direct care rate of \$82.85. AR 566, 568; Appendix F, pp. 5, 7.

IV. ARGUMENT IN RESPONSE

The Department's determination of the Appellants' July 1, 2007, Medicaid payment rate was entirely consistent with the clear intent of the Legislature as expressed in the plain language of the relevant statutes. As discussed in detail below, the Department correctly included case mix weights derived from 1999 data in the July 1, 2007, Medicaid payment rate for direct care because the rate was calculated using an average of the four quarterly FACMI scores from 2005. The 2005 FACMI scores, calculated in 2005, used case mix weights from the then-most-recent rebase: July 1, 2001. The 2001 rebase, in turn, correctly used cost report and wage ratio data from 1999. This Court should reject the Appellants' claims and affirm the Department's final decision on the determination of the Appellants' Medicaid payment rates, as reflected in the Department's Decision and Final Order and the Superior Court's Order.

A. Standard Of Review

Review of administrative agency action is governed by the Washington Administrative Procedure Act (APA), Chapter 34.05 RCW. When the Court of Appeals reviews an administrative agency's action, it sits in the same position as the Superior Court and applies the standards of the APA directly to the record before the agency. *Tapper v.*

Employment Sec. Dep't, 122 Wn.2d 397, 402, 858 P.2d 494, 498 (1993) (citations omitted).

In an APA judicial review of an agency action, the party asserting the invalidity of the agency's action bears the burden of establishing the invalidity thereof. RCW 34.05.570(1)(a). When the agency action being challenged is an agency order issued in an adjudicative proceeding, a reviewing court may invalidate the agency's order only for specific, enumerated reasons. RCW 34.05.570(3); *Ames v. Dep't of Health*, 166 Wn.2d 255, 260, 208 P.3d 549, 551 (2009) (citations omitted). In this case, the Appellants allege that the Department's order was invalid for the reason set forth only in RCW 34.05.570(3)(d)—that the Department “erroneously interpreted or applied the law.” Thus, the Appellants bear the burden of establishing that the Department erroneously interpreted or applied the law. RCW 34.05.570(1)(a).

The Appellants did not challenge any of the Department's factual findings. *Appellant's Opening Brief*, p. 2. “Uncontested findings of fact are deemed verities on appeal.” *Haley v. Medical Disciplinary Bd.*, 117 Wn.2d 720, 728, 818 P.2d 1062, 1067 (1991). The Appellants challenged only Conclusions of Law 7 and 9 in the Department's Decision and Final Order. *Appellant's Opening Brief*, p. 2.

While “it is ultimately for the court to determine the purpose and meaning of statutes,” *Overton v. Wash. State Econ. Assistance Auth.*, 96 Wn.2d 552, 555, 637 P.2d 652 (1981), the Court accords “substantial weight to the agency's interpretation of the law it administers—especially when the issue falls within the agency's expertise,” *Ames*, 166 Wn.2d at 261, 208 P.3d at 551 (citations omitted). In this case, the Department’s application of the laws warrants respectful consideration due to the complexity of the Medicaid statutes and the expertise of the agency.

B. The Statutes Required The Department To Use Case Mix Weights Derived From 1999 Cost Report Data When Calculating The FACMI Score Used In The July 1, 2007, Medicaid Payment Rate for Direct Care

Explicit statutory directives required the Department to use an average of the FACMI scores from the four calendar quarters occurring during 2005 when setting the July 1, 2007, Medicaid payment for direct care (also known as the direct care component rate). The statutes also required that the FACMI scores from 2005 use case mix weights from 1999 data. Taking the four below-outlined steps together, it is clear that the Department correctly used case mix weights derived from 1999 cost report data when calculating the FACMI score used in the July 1, 2007, direct care component rate formula.

The Appellants argue that the Department, in calculating the July 1, 2007, Medicaid payment rate for direct care, should have used a FACMI score based on case mix weights updated in 2007. As explained in detail below, the Appellants' argument is contrary to the plain language of the relevant statutes.

1. In Calculating The July 1, 2007, Medicaid Payment Rate For Direct Care, RCW 74.46.431(4)(a) Required The Department To Use Cost Report Data From 2005

The Legislature required the Department to use cost report data from 2005 when calculating facilities' July 1, 2007, Medicaid payment rate for direct care: "Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations." RCW 74.46.431(4)(a). The Department did just that; in calculating each nursing facility's direct care component of the July 1, 2007, Medicaid rate, the Department used the direct care costs from the 2005 cost reports. AR 3 (*Finding of Fact 3*).

2. In Calculating The July 1, 2007, Medicaid Payment Rate, RCW 74.46.501(7)(b)(iii) Required The Department To Use An Average Of The FACMI Scores From The Four Calendar Quarters "Occurring During" 2005

The Legislature also mandated that the Department, when establishing the Medicaid payment rate for direct care, use an average FACMI score from the four calendar quarters occurring during the cost

report period used to rebase the direct care component rate. Specifically, RCW 74.46.501(7)(b)(iii) stated:

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.

Thus, the statute required the Department to use the average of the FACMI scores from the same year as the cost report period used in the rebasing. When read together, RCW 74.46.431(4)(a) and RCW 74.46.501(7)(b)(iii) required the Department to use the 2005 cost report data and the 2005 FACMI (an average FACMI from the four quarters of 2005) from each facility when calculating that facility's July 1, 2007, Medicaid payment rate for direct care. This is exactly what the Department did. AR 3-4 (*Findings of Fact 3 and 4*). The "FACMI computation used in the rate calculation was derived from averaging the FACMI values existing during the four quarters of 2005." AR 3 (*Finding of Fact 4*).

3. The 2005 FACMI Was Calculated In 2005 Using Case Mix Weights From The Then-Most-Recent Rebase: July 1, 2001.

As discussed above, the applicable statutes required that the July 1, 2007, direct care component rate use the 2005 cost report data

and, therefore, the 2005 FACMI score (an average FACMI from the four quarters of 2005). RCW 74.46.431(4)(a); RCW 74.46.501(7)(b)(iii). The 2005 quarterly FACMI scores were calculated in 2005 by multiplying the case mix weight of each resident by the number of days that resident was at each particular case mix classification or group, and then averaging. RCW 74.46.501(1)-(3); AR 8 (*Conclusion of Law* 5).

In 2005, when the FACMI was calculated each quarter, the direct care component had not been rebased since 2001 because the Legislature required 1999 data to be used for five years: from July 1, 2001, through June 30, 2006. RCW 74.46.431(4)(a). In other words, in 2005 the then-most-recent rebase had been in 2001. Because, under RCW 74.46.496(5), case mix weights are revised only when direct care component rates are cost-rebased, the 2001 case mix revision was current when the FACMI scores were calculated each quarter in 2005.

4. The 2001 Rebase Used Cost Report Data From 1999

In 2005, when the Department was calculating the 2005 FACMI scores, the Department was required to use case mix weights updated in 2001. The Legislature required that “adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2006, direct care component rate allocations.” RCW 74.46.431(4)(a). In other words, the 2001 rebase was based on 1999 cost report data. Likewise, the “case

mix weight” revisions done in 2001 were based on 1999 Registered Nurse, Licensed Practical Nurse, and Certified Nursing Aide wage ratios. AR 3-4 (Finding of Fact 4).

In summary, the Department was required to use the 2005 cost report data and the 2005 FACMI when calculating the July 1, 2007, direct care component rate. RCW 74.46.431(4)(a); RCW 74.46.501(7)(b)(iii); AR 9 (*Conclusion of Law 7*). The 2005 FACMI was calculated by averaging the four FACMI scores calculated during the four quarters of 2005—a year during which case mix weights were based on 1999 wage ratio data. AR 3-4 (*Finding of Fact 4*). The Department correctly used wage ratios from 1999 in calculating the FACMI score used in establishing the Appellants’ July 1, 2007, Medicaid payment rate.

C. The Department Did Revise The Case Mix Weights In 2007, As Required By RCW 74.46.496(4) And (5)

The bulk of the Appellants’ opening brief is focused on their erroneous conclusion that the Department failed to revise the case mix weights when the direct care component rates were rebased in 2007. *E.g., Appellants’ Brief, p. 9-10.* Yet the Appellants simultaneously concede in their brief that the Department did revise the case mix weights in 2007, as required by RCW 74.46.496(4) and (5). *Appellants’*

Brief, p. 5 (“The Department revised the case mix weights in the July 1, 2007 rate setting ...”). The Appellants argue that the Department failed to “incorporate the revised case mix weights in the FACMI portion of the calculation.” *Id.*

The Appellants’ assertion is misleading and incorrect. The Department incorporated the 2007 revised case mix weights into the FACMI scores calculated in 2007. AR 10-11 (*Conclusion of Law 9*). But the 2005 FACMI scores—not the 2007 FACMI scores—were the input used in calculating the July 1, 2007, direct care component rate. AR 3-4 (*Finding of Fact 4*). The case mix weights updated in 2001 (based on 1999 wage ratio data) were incorporated into the 2001, 2002, 2003, 2004, and 2005 FACMI scores. *See id.* The Department’s 2007 revision to the case mix weights (based on 2005 data) affected the FACMI scores calculated in 2007; the 2007 revisions to the case mix weights had no impact on the FACMI scores calculated previously in 2005. The 2005 FACMI score must be used in calculating the July 1, 2007 rates. RCW 74.46.501(7)(b)(iii); RCW 74.46.431(4)(a). Likewise, the 2007 FACMI score must be used in calculating the July 1, 2009 rates. *Id.* Due to the statutory scheme, there is a lag in time before the updated case mix weights are reflected in any facility’s Medicaid rate.

D. The Department Followed the Plain Statutory Requirements And Construed RCW 74.46.501(7)(b)(iii) As Being In Concert With, Not Conflict With, The Other Applicable Statutes

In the Appellants' Opening Brief, they argue that the Department's conclusions improperly construed the statutes as being in conflict with each other. *Appellants' Brief*, p. 13. But the Department's Decision and Final Order found that acceptance of the Department's interpretation and application of the relevant statutory provisions was the only conclusion that reconciled and implemented both RCW 74.46.501(7)(b)(iii) and RCW 74.46.496(4) and (5). AR 11 (*Conclusion of Law 9*). The Department noted that the *Appellants'* position was "in conflict with RCW 74.46.501(7)(b)(iii)." *Id.* Furthermore, the superior court judge, in affirming the Department, also found "no ambiguity in the sections of chapter 74.46 RCW at issue here." CP 81.

Where statutes relate to the same subject matter, the reviewing court should "read them as a unified whole to the end that a harmonious statutory scheme evolves which maintains the integrity of the respective statutes." *Anderson v. Dep't of Corrections*, 159 Wn.2d 849, 861, 154 P.3d 220, 226 (2007) (citations omitted). The Appellants' position is wholly inconsistent with the plain meaning of RCW 74.46.501(7)(b)(iii): that the Department shall use an average of FACMI scores from the four

calendar quarters occurring during the cost report period used to rebase, i.e, the FACMI scores calculated during 2005. The Department's interpretation, on the other hand, gives meaning to all of the statutory provisions.

E. RCW 74.46.501(7)(a) and (c) Required The Department To Use The First-Quarter 2007 MACMI Score In Calculating The July 1, 2007, Medicaid Payment Rates

The Appellants devote a significant portion of their opening brief to the misleading argument that "it is critical that both the MACMI and the FACMI be determined using the same case mix weights." *E.g., Appellants' Brief, p. 11.* The Appellants go on to claim that the Department "seeks to add a condition to the statute [that] would allow it to revise the case mix weights for only the MACMI and not the FACMI." *Id.* at 12. The Appellants' argument both disguises the facts and misinterprets the statutory requirements.

The Legislature mandated that the Department use FACMI and MACMI differently in the calculation of the July 1, 2007, direct care component rate. The FACMI is used "throughout the applicable cost-rebasing period," whereas the MACMI "shall be used to update a nursing facility's direct care component rate quarterly." RCW 74.46.501(7)(a). Furthermore, when establishing the direct care component rates, the Department is mandated to "use an average of

facility case mix indexes [FACMI] 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”—i.e., the four quarters of 2005. RCW 74.46.501(7)(b)(iii) (emphasis added). But a different subsection of the statute, RCW 74.46.501(7)(c), instructs the Department to use the MACMI “from the calendar quarter commencing six months prior to the effective date of the quarterly rate.” RCW 74.46.501(7)(c). The Department has always maintained that when the Department updated the case mix weights in 2007, those updated case mix weights were applied to the FACMI and MACMI scores for all four quarters of 2007. *E.g.*, Verbatim Report of Proceedings 51-52; CP 61, n. 2. In other words, the first-quarter 2007 MACMI and the first-quarter 2007 FACMI were both updated with the new case mix weights in 2007.

In calculating the July 1, 2007, direct care component rate, the Department used the first-quarter 2007 MACMI: the quarterly MACMI score from January – March, 2007. AR 3 (*Finding of Fact 3*). The Legislature required the Department, in calculating the direct care component rate for July 1, 2007, to use the 2005 FACMI (the average of all four quarters in 2005) and the first-quarter 2007 MACMI. RCW 74.46.501(7)(b)(iii), (c). In other words, the law required the

Department to look to two different periods in time in determining which FACMI and which MACMI to use in calculating the July 1, 2007, rates. Due to the lag built into the statute, the first-quarter 2007 MACMI affected the July 1, 2007 Medicaid rates, whereas the first-quarter 2007 FACMI did not affect Medicaid rates until July 1, 2009.

V. CONCLUSION

In setting each Appellant's July 1, 2007, Medicaid payment rate for direct care, the Department properly used an average of the FACMI scores from the four calendar quarters occurring during 2005, which were properly based on case mix weights derived from 1999 data. The Appellants' claims on this issue should be rejected.

The Department requests that this Court AFFIRM the Superior Court's Order and AFFIRM the Department's Decision and Final Order.

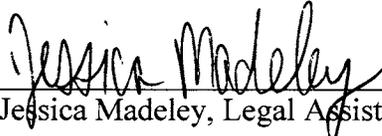
RESPECTFULLY SUBMITTED this 10th day of September, 2010.

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CERTIFICATE OF SERVICE

I certify that I mailed a copy of the foregoing Brief of Respondent to John F. Sullivan, Attorney for Appellant, at Inslee, Best, Doezie & Ryder, P.S., PO Box 90016, Bellevue, WA 98009-9016, postage prepaid, on September 10, 2010.



Jessica Madeley, Legal Assistant

FILED
COURT OF APPEALS
DIVISION II
10 SEP 13 AM 9:40
STATE OF WASHINGTON
BY  _____
DEPUTY

1 The goal of this undertaking is to enforce the statutes enacted by the legislature; in other
2 words, to ascertain the intent of the legislature and to give effect to that intention. The review
3 judge's recitation of the principles of statutory interpretation from the *Tarver v. Smith* decision,
4 quoted in his Conclusion of Law No. 9, are applied in my decision as well, and do not require
5 repeating.

6 I find no ambiguity in the sections of chapter 74.46 RCW at issue here. Accordingly, I
7 conclude that construction of the statutes to change from their plain meaning is not warranted.

8 In arguing their appeal, petitioners give primacy to the language of §.496 over the language
9 of §.431(4)(a) and §.501(7)(b)(iii). As concluded by the review judge, subsections (4) and (5) of
10 §.496 do not specifically state that the case mix weights shall be revised so as to affect the July 1
11 Medicaid rate within the year of the revision. Petitioners' position depends on an inference of that
12 intention drawn from the language of those two subsections. Standing alone, such an inference
13 drawn from the language of those two subsections, (4) and (5) of §.496, is not unreasonable. But it
14 is well established that the intent of the legislature is to be gleaned from reading the legislation
15 (sections, chapters, or Acts) as a whole. Chapter 74.46 RCW is divided into parts, including the
16 part titled *Rate Setting*, wherein is found sections .431, .496, and .501. These three sections should
17 be read as a whole to determine the intent of the legislature; and when they are, I conclude that the
18 inference urged by petitioners is impermissible.

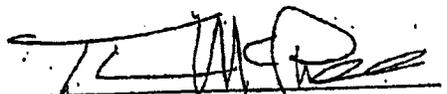
19 I conclude, as did the review judge, that the language in §.431(4)(a) and §.501(7)(b)(iii) is
20 specific and directly on point regarding the use of 1999 adjusted cost report data in the FACMI
21 formula for the rate calculation at issue here. It is clear that the legislature has directed that the
22 FACMI formula be changed to replace the 1999 adjusted cost report data with more current data
23 moving forward. But an inference drawn from the language of §.496(4) and (5) that the updated
24 FACMI must be used in the rate calculation for 2007 is not a reasonable inference in light of the
25 specific intent of the legislature expressed in the other two statutes. Such an inference cannot create
26 an ambiguity that requires construction beyond the interpretation of the three statutes given them by
27 the Review Judge.

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1 One may argue that the legislative scheme to separate the data used in the FACMI formula
2 from its application to rates set eight years later is unwise (or even an unintended result), but this is
3 a policy (or political) argument to be made to the legislature; it is not the province of a court to
4 substitute its judgment for that expressed by the legislature in a plainly worded statute.

5 The final administrative decision is affirmed. Respondent is the prevailing party; counsel
6 should present an appropriate order.

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8 Date: March 2, 2010


Thomas McPhee, Judge

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
BOARD OF APPEALS

In Re:

LIFE CARE CENTER OF BOTHELL
HALLMARK MANOR
ALDERWOOD MANOR
COTTESMORE OF LIFE CARE
LIFE CARE CENTER OF PORT ORCHARD
LIFE CARE CENTER OF KENNEWICK
LIFE CARE CENTER OF MARYSVILLE
LIFE CARE CENTER OF MOUNT VERNON
LIFE CARE CENTER OF PUYALLUP
LIFE CARE CENTER OF RITZVILLE
LIFE CARE CENTER OF SKAGIT VALLEY
LANDMARK CARE CENTER
LIFE CARE CENTER OF BURIE
CASCAD PARK CARE CENTER
LIFE CARE CENTER OF FEDERAL WAY
ISLANDS CONVALESCENT CENTER
KAH TAI CARE CENTER
LAKE VUE GARDENS CONVALESCENT
CENTER
LIFE CARE CENTER OF WEST SEATTLE
LIFE CARE CENTER OF RICHLAND
OCEAN VIEW CONVALESCENT CENTER;
and
PROVIDENCE MT. ST. VINCENT
PROVIDENCE MARIANWOOD
RIDGEMONT TERRACE;
and
FAIRFIELD GOOD SAMARITAN CENTER
STAFHOLT GOOD SAMARITAN CENTER
FORT VANCOUVER CONVALESCENT
CENTER
JUDSON PARK HEALTH CENTER
SPOKANE VALLEY GOOD SAMARITAN
VILLAGE

Appellants.

Docket No.
12-2007-N-1245
12-2007-N-1248
12-2007-N-1250
12-2007-N-1253
01-2008-N-0421
01-2008-N-0579
01-2008-N-0580
07-2008-N-1390
01-2008-N-0581
01-2008-N-0582
01-2008-N-0691
01-2008-N-0948
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01-2008-N-0964
01-2008-N-0966

01-2008-N-0968
01-2008-N-1211
07-2008-N-1391

02-2008-N-0424
02-2008-N-0603
01-2008-N-1620

03-2008-N-0598
03-2008-N-0599
03-2008-N-0601

03-2008-N-0660
03-2008-N-1362

DECISION AND FINAL ORDER

July 1, 2007, Medicaid Payment Rate

MAILED
JAN 28 2009
DSHS
BOARD OF APPEALS

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I. NATURE OF ACTION

The Appellant nursing care facilities timely requested administrative hearings to challenge the Department of Social and Health Services' (Department) adjustments to the facilities' cost reports affecting their respective July 1, 2007 Medicaid payment rates. The Department and the facilities resolved all but two of the issues by either written stipulation or mutual agreement.

The Department's proposed exhibits, designated as "D-1" through "D-6", and the Appellants' proposed exhibits, designated as "A" through "M", were admitted into the hearing record. The Administrative Review Conference (ARC) letters issued by the Department to each of the facilities along with the individual requests for hearing were entered as Exhibits "J-1" through "J-29."

An in-person hearing was held on October 7, 2008, to address the remaining two issues. Kenneth Callaghan and Donna Pierson attended and gave testimony for the Department. Raymond Whitlow attended and gave testimony for the Appellants. The parties submitted written post-hearing closing arguments.

II. ISSUES

1. Was the Department correct in using Registered Nurse (RN), License Practical Nurse (LPN), and Certified Nursing Assistant (CNA) average hourly wage ratios from 1999 in calculating the Facility Average Case Mix Index (FACMI) used in establishing each of the facilities' July 1, 2007 Medicaid rate?

2. Was the Department correct in not excluding costs from reported "home or central office" costs that would have been incurred by a facility operating without a home or central office when such costs are non-duplicative, documented, ordinary, necessary, and related to the provision of care services for authorized residents and, thus, subjecting a portion of those costs to disallowance by application of the "home office" cost median lid?

III. FINDINGS OF FACT

1. The Department of Social and Health Services ("DSHS," or "Department") administers the cooperative federal-state Medicaid program in Washington pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396-1396v). As part of this program, the Department compensates nursing care facilities for services to their Medicaid-eligible residents by means of the "nursing facility Medicaid payment system."¹ The Office of Rates Management, within the Department's Aging and Disabilities Services Administration, administers the nursing facility Medicaid payment system.

2. The Appellant facilities are licensed nursing homes in Washington State and are contractors with the Department in the Medicaid program under Title XIX of the federal Social Security Act.

3. In calculating Alderwood Manor nursing facility's Direct Care Component of the July 1, 2007 Medicaid per patient per-day rate, the Department divided the adjusted direct care costs from the 2005 cost reports by the 2005 adjusted patient days for Direct Care. This number was then divided by a value identified as the Facility Average Case Mix Index (FACMI). After application of any "ceilings" (corridors), the resulting "cost per case mix" was multiplied times a value identified as the Medicaid Average Case Mix Index (MACMI) derived from the first quarter of 2007. The resulting "case mix Direct Care rate" was adjusted for vendor rate increases and a low wage worker adjustment resulting in a Direct Care Component of \$82.85 for July 1, 2007.²

4. The FACMI computation used in the rate calculation was derived from averaging the FACMI values existing during the four quarters of 2005 and was based on "case mix weight"

¹ See RCW 74.46.010 *et seq.*

² Both remaining issues deal with interpretation and application of relevant statutes and/or regulations and resolution of these issues does not rely particularly on facts specific to any individual appellant facility nor are the material facts in dispute. For these reasons, and to avoid unnecessary submission of documents, the parties agreed that documents relating to Alderwood Manor were representative of the "FACMI" issue as it affected the other appellant facilities. The parties also agreed that documents relating to Providence Marianwood are representative of the "Home Office Lid" issue as it affected the other appellant facilities.

calculations done in 2001. These "case mix weight" calculations were based on 1999 RN, LPN, and CNA average hourly wage and benefit rates.

5. At least three of the appellant Facilities use a "Home" or "Central" office for the purpose of centralizing services in support of the individual nursing home facility. These facilities report allowable costs associated with and paid through the home or central offices.

6. Each facility using a home office submits an annual home office cost report showing the expenses paid through and any revenue associated with the home office. Accompanying this report is an allocation sheet showing how the home office costs are allocated from the home office cost report to the individual nursing home cost reports. These allocated costs are then reported on a form identified as "G-2, HO." The costs are then allocated to the appropriate cost center on "Schedule G," which is used in calculating the individual facility's Medicaid rate.

7. The Department rate analyst reviews the home office cost reports, the allocation sheets, the G-2 forms, and the schedule G forms for each of the facilities. Any costs that do not meet the statutory definition of allowable costs are disallowed and not considered in setting each facility's Medicaid rate.

8. The Department creates a list of all nursing facilities in the state that use a home office and arrays the facilities based on the allowable costs identified as home or central office costs. From this list, the Department determines a median home office cost, reduced to a per-patient-day amount, and uses this calculation as a median cap or lid. The per-patient-day lid is multiplied times each facility's audited patient days in arriving at that facility's "Maximum Allowable Home/Central Office Cost." Otherwise allocated allowable home office costs causing the facility to exceed this median lid are not allowed in computing each individual nursing facility's Medicaid rate. Allocated home office costs that cause the facility to exceed the median

lid are adjusted out of the individual nursing facilities rate computation as Reason Code (R.C.) 96 on the facilities' Examination Adjustments.

9. In reviewing cost reports prior to 2006, the Department endeavored to identify those allowable costs paid through the home office that would have been incurred by an individual facility without a home office. Using the discretionary authority afforded by statute, the Department would exclude such costs from the definition of home office costs and, thus, avoid the possibility of such costs being disallowed by application of the home office cost median lid. Because such allowable costs were not disallowed by application of the home office median lid, they were considered in determining the facilities' per patient per day Medicaid rate, subject to other component rate limits or "lids."

10. In reviewing the Appellant facilities' 2006 cost reports for the July 1, 2007 Medicaid rate setting cycle, the Department determined that all allowable costs reported paid through the home or central office would be included in the statutory definition of "home and central office costs." This action subjected these costs to possible disallowance through application of the home office median lid and the statutory disallowance of costs exceeding the median lid. The affected costs are part of the non-property cost components of the Medicaid rate (direct care, support services, and operations) which are based on the 2005 cost reports rather than the 2006 cost reports in establishing the July 1, 2007 Medicaid rate.

IV. CONCLUSIONS OF LAW

Authority and Scope of Review

1. The Appellants made timely requests for administrative hearings to contest the Department's calculations of the facilities' July 1, 2007 Medicaid rates. The Department argues that the Home Office Lid issue is not ripe for adjudication because no justiciable issue exists as the adjusted 2006 cost reports were not used to set component rates affected by the challenged Home Office cost allocations. WAC 388-96-901(1) does allow a contractor (nursing

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facility) to contest the way in which the Department applied a statute or regulation by seeking relief through the administrative review process set forth in WAC 388-96-904. WAC 388-96-904 allows for an administrative review conference and a subsequent administrative hearing if the contractor disagrees with a Department action or determination "relating to the contractor's payment rate, audit or settlement, or otherwise affecting the level of payment to the contractor, or seeking to appeal or take exception to any other adverse action" taken under WAC 388-96 or RCW 74.46. Historically, the undersigned has interpreted this regulatory provision to require the existence of a controversy directly affecting an appellant facility's monetary position (Medicaid rate or repayment after final settlement or audit). This forum was not instituted to provide declaratory or advisory opinions through issuance of final administrative decisions having no affect on Medicaid rates or other monetary concerns of the petitioning facilities. However, to dismiss the Home Office issue at this time for lack of a justiciable issue would leave the facilities in an uncertain position regarding current and future structuring of cost disbursements through a home or central office. Along with this "adverse action," there is no dispute that this is an industry-wide issue with the potential of causing both final settlement disputes as well as disputes over Medicaid payments in future rate setting cycles that are now predictable at least under the current cost re-basing statutory schedule. For these reasons, the undersigned concludes that it would fail to serve administrative efficiency to dismiss the facilities' challenge at this time and enough of an "adverse action" exists under the specific facts of this case to create jurisdiction. There is jurisdiction to hear and decide this matter under WAC 388-96-904(5).

2. When deciding cases for the Washington State Department of Social and Health Services ("Department"), Administrative Law Judges, and Review Judges acting as presiding or reviewing officers, are to hear and decide the issue anew (*de novo*).³

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³ WAC 388-02-215(1) and (6).
Decision and Final Order
Docket No. 12-2007-N-1245, et. al.

3. It is helpful if all parties in the administrative hearing process understand the unique characteristics and specific limitations of this hearing process. An administrative hearing is held under the auspices of the *executive branch of government* and a presiding administrative officer does not enjoy the broad equitable authority held by a superior court judge within the *judicial branch of government*. It is well settled in law and practice that administrative agencies, such as the Office of Administrative Hearings and the Board of Appeals, are creatures of statute, and, as such, are limited in their powers to those expressly granted in enabling statutes, or necessarily implied therein. *Taylor v. Morris*, 88 Wn.2d 586, 588 P.2d 795 (1977). It is also well settled that an ALJ's or a review judge's jurisdictional authority of to render a decision in an administrative hearing is limited to that which is specifically provided for in the authorizing statute or Department rule found in the Washington Administrative Code (WAC). An ALJ or review judge acting as a presiding or reviewing officer, is required to apply the Department's rules adopted in the WAC as the first source of law to resolve an issue. If there is no Department rule governing the issue, the presiding officer is to resolve the issue on the basis of the best legal authority and reasoning available, including that found in federal and Washington constitutions, statutes and regulations, and court decisions.⁴ The presiding officer may not declare any rule invalid and contractor challenges to the legal validity of a rule relating to the nursing facility Medicaid payment system must be brought *de novo* in a court of proper jurisdiction.⁵ The Department has incorporated into its nursing facility Medicaid payment system rules the provisions of chapter 74.46 RCW as if fully set out in the Department's rules.⁶

Facility Average Case Mix Index

4. In determining the resources necessary to meet the direct care requirements of residents in a skilled nursing facility, the Department employs the resource utilization group III case mix classification methodology. Residents in licensed skilled nursing facilities are assigned

⁴ WAC 388-02-0220.

⁵ WAC 388-02-0225 (1) and 388-96-901 (3), respectively.

⁶ WAC 388-96-020.

to one of 44 Resource Utilization Groups (RUG) based on the level of care the resident requires.⁷

5. The Facility Average Case Mix Index or FACMI is a numerical value associated with the resident care acuity of a nursing facility. This value is determined by multiplying the "case mix weight" of each resident by the number of days the resident was at each particular case mix classification or group and then averaging.⁸ Quarterly "case mix weights" of each resident of a facility are determined from individual resident assessments and weighted by the number of days the resident was in each case mix classification group.⁹

6. In making the calculations set forth in Conclusion of Law 5, above, it is necessary to assign a "case mix weight" to each of the case mix classifications or groups. Each RUG is assigned a "case mix weight" which is based on the average RN, LPN, and CNA minutes used by each RUG as determined by national time study surveys done in 1995 and 1997.¹⁰ The necessary case mix weights are calculated and assigned to each RUG 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.¹¹

⁷ RCW 74.46.485 (1).

⁸ RCW 74.46.501(3).

⁹ RCW 74.46.496 (1).

¹⁰ RCW 74.46.496(2).

¹¹ RCW 74.46.496(3).

Because the computation set forth in subparagraph (a), above, is a ratio, changes in the difference between RN and CNA wages and changes in the difference between LPN and CNA wages affect the calculated case mix weights and, thus, the final FACMI used in calculating the facilities' Direct Care Component of their respective July 1, 2007 Medicaid rates. The wage rate ratios between CNAs and RNs and between CNAs and LPNs is an intricate part of establishing the applicable FACMI. Statutorily mandated revisions of the FACMI intend re-computation of these wage rate ratios.¹²

7. The Department relies on RCW 74.46.501(7)(b)(iii) in support of its position.

That statutory section provides:

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.

In rebasing the Direct Care component rate allocation for the July 1, 2007 Medicaid rate, the Department is directed by RCW 74.46.431(4) to use adjusted cost report data from 2005. Based on RCW 74.46.501(7)(b)(iii), it follows that the Department must use an average of the facility case mix indexes for the four calendar quarters occurring in 2005. This the Department has done. By statute, the Direct Care component rates were cost-rebased in 2001 based on the 1999 cost reports. Because the Direct Care component rates had not been cost-rebased as of 2005 since 2001, the 2005 FACMI values were based on the 2001 adjusted cost reports which included the case mix weights derived from the 1999 RN, LPN, and CNA average hourly rate ratios determined under RCW 74.46.496(3).¹³ The Department, in computing the quarterly FACMIs in 2005, correctly used the 1999 average hourly rates for RNs, LPNs, and CNAs.

¹² See the last sentence of RCW 74.46.496(4).

¹³ The most recent adaptation of the relevant statute requiring a cost-rebasing of the Direct Care component rate allocation for July 1, 2006, based on 2003 adjusted cost report data, was not effective until July 1, 2007, after the computation of the quarterly FACMIs in 2005. See Notes following RCW 74.46.431: **Effective date—2007 c 508** referencing the effective date notes following RCW 74.46.410. Decision and Final Order

8. The Appellants assert that the Department's position ignores the statutory provisions in RCW 74.46.496 subparagraph (4) providing, "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" and subparagraph (5) providing, "Case mix weights shall be revised when direct care component rates are cost-rebased as provided in RCW 74.46.431(4)." The dispute revolves around the term "effective" as used in RCW 74.46.496(4) and the directive in RCW 74.46.501(7)(b)(iii) requiring use of the FACMI (and, thus, the case mix weights) existing during the four quarters of the cost report period used to rebase the Direct Care component rate allocations.

9. The Washington Supreme Court has ruled that:

"The main purpose of statutory interpretation is first to ascertain and then to give effect to the legislative intention. *Krystad v. Lau*, 65 Wn.2d 827, 844, 400 P.2d 72 (1965). In discharging this duty, the court first looks at the language of the statute. *Schneider v. Forcier*, 67 Wn.2d 161, 406 P.2d 935 (1965). If the language is clear and the meaning plain, the statute needs no construction and the courts will neither read into it things which are not there nor amend it by construction. *King County v. Seattle*, 70 Wn.2d 988, 425 P.2d 887 (1967). A statute should be read as a whole and legislative intent derived from it as a whole. *Krystad v. Lau, supra; Finley v. Finley*, 43 Wn.2d 755, 264 P.2d 246 (1953). Legislative intent cannot be ascertained from a single sentence or even a solitary isolated paragraph (*Markham Adv. Co. v. State*, 73 Wn.2d 405, 439 P.2d 248 (1968)), for the meaning of a particular part or section of a statute is to be taken in context with the parts or sections in which it is found. *Nationwide Papers, Inc. v. Northwest Egg Sales, Inc.*, 69 Wn.2d 72, 416 P.2d 687 (1966); *Mercer Island v. Kaltenbach*, 60 Wn.2d 105, 371 P.2d 1009 (1962).

Tarver v. Smith, 78 Wn.2d 152, 155, 470 P.2d 172 (1970).

Contrary to the Appellants' position, RCW 74.46.496(4) and (5) do not specifically state that the case mix weights shall be revised so as to affect the July 1 Medicaid rate within the year of the revision. RCW 74.46.496 subparagraphs (4) and (5) simply require a revision of the case mix weights when the Direct Care component rates are cost-rebased effective with July 1 of the rebase year. This is what the Department has done and the revision will be "effective" in recalculating the FACMIs for the last two quarters of 2007 which, pursuant to RCW

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74.46.501(7)(b)(iii), does not affect the July 1, 2007 Medicaid rates, but will be used in determination of the July 1, 2009 Medicaid rates. RCW 74.46.496(4) and (5) are general directives to revise the case mix weights when Direct Care component rates are cost-rebased effective July 1st of the rebase year. RCW 74.46.501(7)(b)(iii) is a specific directive as to what FACMI values are to be used when cost-rebasing in a particular rate setting cycle. The language in RCW 74.46.501(7)(b)(iii) is clear and the meaning plain, the statute needs no construction and the undersigned can neither read into it things which are not there nor amend it by construction. The revised case mix weights brought about by the most recent cost-rebasing are "effective" as of July 1, 2007, and will now be used, absent future relevant legislative changes, in calculation of the July 1, 2009 Medicaid rates pursuant to the last sentence of RCW 74.46.431(4)(a) and RCW 74.46.501(7)(b)(iii). The Department's actions regarding this issue give meaning and effect to both RCW 74.46.501(7)(b)(iii) and 74.46.496(4) and (5). The Appellants' position, although appearing to comply with RCW 74.46.496(4) and (5), standing alone, is in conflict with RCW 74.46.501(7)(b)(iii).¹⁴ Acceptance of the Department's interpretation and application of the two relevant statutory provisions is the only conclusion that reconciles and implements both provisions.

¹⁴ The Appellants argue that the Department's treatment of the FACMI and Medicaid Average Case Mix Index (MACMI) is inconsistent. However, the relevant statute requires looking to two different periods in determining what FACMI and what MACMI is to be used. The statute directs that the FACMI from the four quarters (averaged) of the cost report period used in the re-basing of the Direct Care cost component (2005 in this case) is to be used. The statute also directs that the MACMI be taken from the calendar quarter commencing six months prior to the updated rate (which would be January – March, 2007). Thus, the applicable MACMI is based on more recent average hourly nursing rate ratios due to the cost-rebasing of the Direct Care cost component in 2006 pursuant to RCW 74.46.431(4). The undersigned recognizes that this legal conclusion results in use of wage data approximately 8 years old as one element in setting the July 1, 2007 Medicaid rate. However, this was caused by the considerable length of time the legislature allowed the Medicaid rate to go without cost re-basing and cannot change the application of the relevant statutes.

*Inclusion of Allowable Costs in Home and Central Office Costs*¹⁵

10. Statutory definitions relevant to the "Home Office Median Lid" issue are found at RCW 74.46.020(30) and 74.46.410(2)(xx) and provide, respectively:

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

"Unallowable costs include, but are not limited, to the following:
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. . . ."

The Washington State Supreme Court has ruled, "Under Washington law, it is well-established the use of the term "may" in a statute is regarded as permissive or discretionary, while the use of the term 'shall' is regarded as mandatory. See, e.g., *Erection Co. v. Dep't of Labor & Indus.*, 121 Wn.2d 513, 518, 852 P.2d 288 (1993) ('The word "shall" in a statute . . . imposes a mandatory requirement unless a contrary legislative intent is apparent'); *Streng v. Clarke*, 89 Wn.2d 23, 28, 569 P.2d 60 (1977) (noting that words in a statute must be given their ordinary meaning unless a contrary intent appears and that '[t]he ordinary meaning of the word "may" conveys the idea of choice or discretion')."
Crann v. Carver, 2006 U.S. Dist. LEXIS 78188.¹⁶

¹⁵ The Department's decision not to exclude certain otherwise allowable costs from the definition of home and central office costs raises an issue of interpretation and application of relevant statutes and/or regulations. Resolution of this issue does not rely particularly on facts specific to any individual appellant facility nor are the material facts in dispute. The same issue was presented recently in a separate hearing involving several other skilled nursing homes. Because the issue presents a dispute over the interpretation and application of law rather than of fact, the two decisions addressing the issue are similar and are being issued simultaneously. This is to provide, hopefully, some issue uniformity and consistency to the industry as a whole.

¹⁶ Those decisions holding the use of the term "may" as mandatory are distinguishable from the case at bar as they involved what a party must do to protect procedural appeal rights. See *Northwest Ecosystem Alliance v. Wash. Forest Practices Bd.*, 149 Wn.2d 67, 66 P.3d 614, 2003, citing *Muije v. Department of Social & Health Services*, 97 Wn.2d 451, 453, 645 P.2d 1086 (1982), "where [the court] held that a statute providing that a person "may appeal [a decision of the Board] to the superior court of Thurston county" was not merely permissive, but instead provided the sole and exclusive place of venue."

Decision and Final Order

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11. The use of the term "may" in RCW 74.46.020(30) denotes a granting to the Department of discretionary authority to exclude from the definition of "home and central office costs" those costs that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized residents of the nursing facility. The initial question that must be addressed is, "Does the undersigned have jurisdictional authority to reverse or 'second guess' the Department's discretionary decision not to exclude certain costs that it clearly has authority to exclude under the statute if it so chooses to do so?"

12. In addressing the issue of one tribunal's review of another tribunal's discretionary decisions, the Washington Court of Appeals Division III has ruled, "[T]he legislature's use of the term "may" in a statute generally confers discretion. We will not disturb such an exercise of discretion on appeal absent a showing of abuse. *State ex rel. Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971). Abuse of discretion occurs where the trial court's action is "manifestly unreasonable, or exercised on untenable grounds, or for untenable reasons." *Id.* *In re Freeman*, 146 Wn. App. 250; 192 P.3d 369 (2008). Use of the Appellant Court's guidelines for reviewing the Department's discretionary decision to include certain costs in the definition of home or central office costs in this case is somewhat troublesome because the relevant statute does not lay out any basis or reasons as to when the Department should exclude allowable costs from the definition. It is difficult, at best, to determine from the statutory definition what would constitute reasonable or untenable grounds in exercising the granted discretionary authority. Furthermore, review of a Department's discretionary actions based on assertions that such actions are arbitrary and capricious is normally reserved for judicial review. See RCW 34.05.570(3)(i).

13. Notwithstanding the forgoing legal conclusions, the review judge, acting as a presiding officer in a Nursing Home Rate case, sits in a position somewhat different than a Superior Court judge reviewing a final administrative order or even an Appellant Court judge

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reviewing a lower court's decision. Although not involved in the Aging and Disabilities Service Administration of the Department, a review judge is an employee of the Department and is designated by the agency head to enter final orders.¹⁷ The undersigned recognizes that the terms "the department shall" and "the department may" are both used throughout RCW 74.46 and WAC 388-96 in defining Department duties in setting nursing home Medicaid rates. For this reason, the undersigned must carefully consider the cited case law concluding the use of the term "may" as permissive rather than mandatory. Where the legislature has given clear permissive discretion to the Department in making decisions affecting Medicaid rates, the undersigned should be extremely reluctant to second guess such decisions made by the Department's rate analysts. However, it must also be recognized that some of the statutory and regulatory provisions using the term "may," such as those that state "the department may make adjustments to cost reports" or "the department may assess civil fines" clearly have hearing rights attached and are subject to administrative review.¹⁸ When the legislature provides the Department with the "permissive" authority to adjust cost reports, it expects the Department to exercise that discretionary authority to accurately establish a nursing facility's Medicaid rate, reading and applying the relevant chapter of the RCW as a whole whenever possible. Based on the circumstances surrounding the discretionary decision made in this case and the role of the review judge as discussed above, the undersigned would be remiss in simply deferring to the Department's decision not to exercise its discretionary authority to exclude certain allowable costs from the home and central office definition.

14. As set forth in *Conclusion of Law 9*, above, the starting place for any exercise in statutory interpretation is to ascertain and give effect to legislative intent. The undersigned accepts that the legislature does not enact a law or create language in a statute without

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¹⁷ See WAC 388-02-0010 "Review judge," RCW 34.05.425(1)(b), RCW 74.46.780, and WAC 388-96-904(5)

¹⁸ See for examples RCW 74.46.100(3) and RCW 74.46.050(2).

purpose or grant discretionary authority without the intent of that authority being exercised when appropriate.

15. Reading RCW 74.46.020(30) and 74.46.410(2)(xx) in context with the rest of RCW 74.46, the undersigned is convinced that the legislature's purpose in creating median lids on home or central office costs was to reign in those excessive costs uniquely associated with establishing and maintaining a centralized office based on a state-wide review and comparison of such centralized operations. As an example, a corporation could choose the most posh headquarters for its nursing home central office and hire the highest paid employees to staff the headquarters, but could not expect full compensation through the Medicaid rate process when other such situated facilities were exercising restraint and prudence in incurring expenses associated with the establishment and maintenance of a nursing home central operation. The fact that the legislature gave the Department discretionary authority to exclude otherwise allowable costs from the definition is evidence that the legislature did not intend to limit by application of a home office lid allowable costs paid through a home or central office that would have been incurred by the facilities as "stand-alone" operations. The undersigned finds this to be the only discernible purpose for the granting of the discretionary authority. Nothing in the evidentiary hearing record, or the statute itself, allows for or even infers any other purpose. The Department recognized this statutory purpose in its handling of the issue in rate setting cycles prior to July 1, 2007. The Department provided no other reason for the relevant language in the statute. Notwithstanding this prior recognition, the Department inferred by its position and argument at hearing that it would not, in the future, exercise its authority to exclude such costs even though the statute specifically provides for this action.

16. The Department's reliance on specific language in RCW 74.46.410(2)(xx) is not persuasive as the identifying term, "*whether on or off the nursing facility premises, and whether allocated or not to specific services*" refers to those costs ultimately included in the definition of

home or central office costs. The third sentence of RCW 74.46.020(30) gives the Department authority to initially exclude certain costs from the definition of home and central costs rendering the identifying term inapplicable to such costs once excluded from the definition.

17. The Department also argues that the second sentence of RCW 74.46.020(30), "Home and central office costs include centralized services that are performed in support of a nursing facility," is evidence that the legislature intended for all allowable costs paid through the home or central office to be included in the definition and considered in determination of the home office cost median lid. Again, this interpretation renders meaningless the third sentence of the definition. In drafting and adopting the definition, the legislature must have recognized that there will exist certain "centralized services that are performed in support of a nursing facility" that are unique to the existence of the home or central office and would not have been incurred but for the existence of the centralized office, but still are "performed in support of a nursing facility," as the home office exists for the benefit of and provides services for the individual nursing homes within in its domain. To the extent possible, one sentence of a statutory definition should not be construed so as to render another sentence meaningless or ineffective.

18. The Department argues that exercise of the discretionary authority granted in the third sentence of RCW 74.46.020(30) would leave no home office costs to create a median lid as all allowable costs, by definition, must be nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients. However, this argument ignores the difference between costs incurred unique to the establishment and maintenance of a home office that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients and those costs paid through the home office that are "facility specific" and would have been necessarily incurred whether a home office

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existed or not. The Department has recognized this difference in past rate setting cycles as evidenced by the creation of home or central office cost median lids prior to 2007.

19. Within this argument, the Department asserts that requiring exclusion of costs from calculation of the median lid that would otherwise be allowable and compensated costs in a "stand-alone" facility, would basically render the home cost median lid useless. Again, if these particular allowable costs would exist and be compensated for in the absence of a home office, the fact the payments are made through the home office should not be the sole basis for disallowance of such costs. Acceptance of the Appellants' position may minimize the effect the home office cost median lid will have, but this does not mean the median lid cannot be an effective tool in reigning in those corporations choosing to expend sums on home office operations disproportionate with the costs incurred by similarly situated entities in the state.

20. Under ideal circumstances, the third sentence of RCW 74.46.020(30) would perhaps read, "The department *shall* exclude from this definition costs that **would otherwise have been incurred by a sole contractor without a home or central office when such costs** are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients." However, the authority to exclude such costs is in the current statutory definition and, under the analysis set forth above, such authority exists for the purpose of allowing such costs to be recompensed under Medicaid rate setting process.

21. When a statute grants authority to the Department to bring about a more accurate and even-handed establishment of Medicaid reimbursement for the care of the elderly, failure to exercise that discretion towards that end can lead to inaccurate, inconsistent, arbitrary, and capricious results from year-to-year rate settings and between nursing facilities with similar costs paid through different disbursement methods. As a Department employee assigned final agency decision making authority within the administrative hearing forum, the 000017 undersigned has a responsibility to interpret and apply the law, to the extent possible, so as to

avoid arbitrary and capricious results that would render such Department decisions vulnerable to challenge on judicial review. The evidence in the hearing record and the Department's actions in past rate setting cycles support the Appellants' position that certain allowable costs can be identified as home office costs subject to the home office median lid, while other costs can be identified as pass-through costs that should be excluded from the definition.

22. The undersigned recognizes that requiring the assigned rate analyst to evaluate costs paid through a home or central office to determine if they should be excluded can be time consuming and require considerably more effort than simply choosing to not exercise the exclusionary authority at all. And all this occurring at a time in the rate setting cycle when Department rate analysts are already under extreme time pressures. However, this alone is not a proper basis for refusing to exercise that granted statutory authority. The Department cannot simply ignore the third sentence of RCW 74.46.020(30). The Legislature created the discretionary authority for a reason and, as discussed above, choosing to simply ignore that authority undermines the accuracy and fairness of the Medicaid compensatory system.

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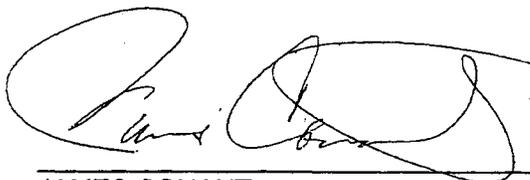
V. DECISION

Based on the conclusions entered above:

The Department's methodology in determining the Facility Average Case Mix (FACMI) used in calculating the Appellants' July 1, 2007 Medicaid rates is affirmed.

The Department's decision to not exclude from the definition of "home or central office costs" any allowable costs paid through a facility home or central office is reversed. The matter is remanded to the Department to exclude from the definition those costs that would be incurred by a "stand-alone" nursing facility which are non-duplicative, documented, ordinary, necessary, and related to the provision of care services for authorized residents.

DATED this day of January, 2009.



JAMES CONANT
Review Judge/Presiding Officer

Attached: Reconsideration/Judicial Review Information

Copies: Life Care Center of Bothell, et. al., Appellants
 John F. Sullivan, Appellants' Representative
 Michael Young, AAG, Department's Representative, MS: 40124
 Edward Southon, Program Administrator, MS: 45600

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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

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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
NDOR
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

Table with columns for Item Number, Description, and Value. Includes items 1 through 34, covering patient days, licensed beds, and inflation factors for 2005 and 2006.

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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
EM 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

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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)
EM 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

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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 (IF ITEM 26 = 0, THEN ITEM 74 / ITEM 30) (IF ITEM 26 > 0 & ESSENTIAL COMMUNITY PROVIDER OR UNBANKING BEDS, THEN ITEM 74 / ITEM 34)	7.40
ITEM 75	PROPERTY RATE PPD (ITEM 75)	7.40
ITEM 76	CURRENT FUNDING FOR CAPITAL IMPROVEMENTS NOT INCLUDED IN REASON CODE 27	0
ITEM 77	CURRENT FUNDING FOR CAPITAL IMPROVEMENTS PPD (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))	0.00
ITEM 78	PROPERTY RATE PPD PLUS CURRENT FUNDING PPD (ITEM 76 + ITEM 78)	7.40

SECTION VII - FINANCING ALLOWANCE COMPONENT

ITEM 80	2006 REPORTED NET BOOK VALUE OF ALLOWABLE ASSETS (SCHEDULE B, COL. 6, LINE 35)	2,516,373
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
ITEM 83	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 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 (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))	7.91
ITEM 85	FINANCING ALLOWANCE PPD FOR ASSETS PURCHASED ON OR AFTER MAY 17, 1999 (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))	0.77
ITEM 86	CURRENT FUNDING - NET BOOK VALUE ASSOCIATED WITH PURCHASES ON OR AFTER MAY 17, 1999	0
ITEM 87	FINANCING ALLOWANCE FOR CURRENT FUNDED NBV PURCHASED ON OR AFTER MAY 17, 1999 (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))	0.00
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

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**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) EXAMINED COST PPD (IF ITEM 26 = 0, THEN ITEM 98 / ITEM 35)	0.00
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
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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>

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**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	<u>158.80</u>

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

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