(123rd General Assembly)
(Substitute House Bill Number 403)

AN ACT

To amend sections 173.19, 3702.525, 3721.21, 5111.20, 5111.25, 5111.251, and 5111.62 and to enact sections 173.45 to 173.59, 3721.026, and 3721.027 of the Revised Code to require the publication of the Ohio Long-Term Care Consumer Guide, to create a nursing facility technical assistance program, to change the method of calculating nursing facilities' and intermediate care facilities for the mentally retarded's Medicaid reimbursement rates for indirect care and capital costs, to specify in the law governing nursing homes that neglect does not include allowing a resident to receive only treatment by spiritual means through prayer in accordance with the tenets of a recognized religious denomination, to require the Department of Health to investigate valid, unresolved complaints that the State Long-Term Care Ombudsperson refers to the Department, to make an exception to the certificate of need implementation deadline, and to make an appropriation.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 173.19, 3702.525, 3721.21, 5111.20, 5111.25, 5111.251, and 5111.62 be amended and sections 173.45, 173.46, 173.47, 173.48, 173.49, 173.50, 173.51, 173.52, 173.53, 173.54, 173.55, 173.56, 173.57, 173.58, 173.59, 3721.026, and 3721.027 of the Revised Code be enacted to read as follows:

Sec. 173.19. (A) The office of the state long-term care ombudsperson program, through the state long-term care ombudsperson and the regional long-term care ombudsperson programs, shall receive, investigate, and

attempt to resolve complaints made by residents, recipients, sponsors, providers of long-term care, or any person acting on behalf of a resident or recipient, relating to either of the following:

(1) The health, safety, welfare, or civil rights of a resident or recipient or any violation of a resident's rights described in sections 3721.10 to 3721.17 of the Revised Code;

(2) Any action or inaction or decision by a provider of long-term care or representative of a provider, a governmental entity, or a private social service agency that may adversely affect the health, safety, welfare, or rights of a resident or recipient.

(B) The department of aging shall adopt rules in accordance with Chapter 119. of the Revised Code regarding the handling of complaints received under this section, including procedures for conducting investigations of complaints. The rules shall include procedures to ensure that no representative of the office investigates any complaint involving a provider of long-term care with which the representative was once employed or associated.

The state ombudsperson and regional programs shall establish procedures for handling complaints consistent with the department's rules. Complaints shall be dealt with in accordance with the procedures established under this division.

(C) The office of the state long-term care ombudsperson program may decline to investigate any complaint if it determines any of the following:

(1) That the complaint is frivolous, vexatious, or not made in good faith;

(2) That the complaint was made so long after the occurrence of the incident on which it is based that it is no longer reasonable to conduct an investigation;

(3) That an adequate investigation cannot be conducted because of insufficient funds, insufficient staff, lack of staff expertise, or any other reasonable factor that would result in an inadequate investigation despite a good faith effort;

(4) That an investigation by the office would create a real or apparent conflict of interest.

(D) If a regional long-term care ombudsperson program declines to investigate a complaint, it shall refer the complaint to the state long-term care ombudsperson.

(E) Each complaint to be investigated by a regional program shall be assigned to a representative of the office of the state long-term care ombudsperson program. If the representative determines that the complaint is valid, the representative shall assist the parties in attempting to resolve it.

If the representative is unable to resolve it, the representative ~~may~~ shall refer the complaint to the state ombudsperson.

In order to carry out the duties of sections 173.14 to 173.26 of the Revised Code, a representative has the right to private communication with residents and their sponsors and access to long-term care facilities, including the right to tour resident areas unescorted and the right to tour facilities unescorted as reasonably necessary to the investigation of a complaint. Access to facilities shall be during reasonable hours or, during investigation of a complaint, at other times appropriate to the complaint.

When community-based long-term care services are provided at a location other than the recipient's home, a representative has the right to private communication with the recipient and the recipient's sponsors and access to the community-based long-term care site, including the right to tour the site unescorted. Access to the site shall be during reasonable hours or, during the investigation of a complaint, at other times appropriate to the complaint.

(F) The state ombudsperson shall determine whether complaints referred to the ombudsperson under division (D) or (E) of this section warrant investigation. The ombudsperson's determination in this matter is final.

Sec. 173.45. As used in sections 173.45 to 173.59 of the Revised Code:

(A) "Clinical quality indicator" means a measure of an aspect of the physical or mental conditions of the residents of a nursing facility that is derived from data taken from resident assessment instruments submitted by nursing facilities for purposes of the medicare and medicaid programs.

(B) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

(C) "Medicare" means the program operated pursuant to Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(D) "Nursing facility" means either of the following:

(1) A facility, or a distinct part of a facility, that is certified as a nursing facility or a skilled nursing facility for purposes of the medicare or medicaid program;

(2) A nursing home licensed under section 3721.02 of the Revised Code that is not certified as a nursing facility or skilled nursing facility.

(E) "Deficiency," "immediate jeopardy," "standard survey," and "substandard care" have the same meanings as in section 5111.35 of the Revised Code.

(F) "Survey data tag" means any of the data tags used in the medicare

and medicaid programs for identification of specific regulatory requirements.

Sec. 173.46. The department of aging shall develop and publish a guide to nursing facilities in this state for use by individuals considering nursing facility placement and their families, friends, and advisors. The guide shall be titled the Ohio long-term care consumer guide.

The consumer guide shall be published in computerized form for distribution over the internet. The guide shall be made available not later than fourteen months after the effective date of this section and shall be updated in accordance with section 173.52 of the Revised Code.

Every two years, the department shall publish an executive summary of the consumer guide, and shall make the executive summary available in both computerized and printed forms.

Sec. 173.47. The department of aging may contract with any person or government entity to perform any function related to the publication of the Ohio long-term care consumer guide or the collection and preparation of data and other material for the guide, except that the department shall contract to have the customer satisfaction surveys conducted under section 173.54 of the Revised Code. In awarding the contract to have the surveys conducted, the department shall contract with a person or government entity that has experience in surveying the customer satisfaction of nursing facility residents and their families. The department's contract shall permit the person or government entity to subcontract with other persons or government entities for purposes of conducting all or part of the surveys.

Sec. 173.48. In developing and publishing the Ohio long-term care consumer guide, the department of aging shall adhere to the following principles:

(A) The guide should be designed to provide users with a variety of measures of nursing facility quality and with other information useful in comparing and selecting nursing facilities.

(B) The guide should present the information specified in division (A) of this section in a manner that is easy to use and understand.

(C) The guide should allow users to determine which of the available measures are most important to them.

(D) The information in the guide should be kept as current as practicable.

(E) The guide should be designed to promote excellence in nursing facility quality.

(F) The guide should promote awareness of the range of long-term care services available to Ohioans.

Sec. 173.49. With regard to the accessibility of the Ohio long-term care consumer guide and the executive summary of the guide, the following shall apply:

(A) The department of aging shall make the guide and summary available to any person or government entity and shall not restrict access by requiring payment of a fee, use of a password, or fulfillment of any other condition.

(B) The department of aging shall develop and implement programs and other strategies to encourage use of the guide by individuals considering nursing facility placement and their families, friends, and advisors.

Sec. 173.50. The Ohio long-term care consumer guide shall include information on each nursing facility in this state. For each facility, the guide shall include, to the extent it is available to the department of aging, all of the following information:

(A) Customer satisfaction data obtained under section 173.54 of the Revised Code;

(B) Clinical quality indicator data obtained under section 173.56 of the Revised Code;

(C) Data derived from standard surveys as specified in division (C)(3) of section 173.51 of the Revised Code;

(D) Any other information specified in sections 173.45 to 173.59 of the Revised Code or the rules adopted under section 173.57 of the Revised Code.

Sec. 173.51. The Ohio long-term care consumer guide shall be structured in accordance with this section and any applicable rules adopted under section 173.57 of the Revised Code.

(A) The opening electronic page of the consumer guide shall include all of the following general information:

(1) A description of the guide;

(2) Disclaimers stating the limitations of the data included in the guide. The disclaimers shall include a statement that standard surveys of nursing facilities are conducted at periodic intervals and a statement that conditions at a facility can change significantly between standard surveys.

(3) A recommendation that individuals considering nursing facility placement visit any facilities they are considering;

(4) Electronic links to other information on the internet about selecting nursing facilities and about other long-term care options, including information maintained by pertinent government agencies and private organizations and telephone numbers for those agencies and organizations;

(5) Any other information the department of aging specifies in rules

adopted under section 173.57 of the Revised Code.

(B) The consumer guide shall be structured in a manner that allows the user to search for information in the guide in multiple ways, including searches by facility name, county, municipality, postal zip code, source of nursing facility payment, and special care service.

(C) The first information to appear on the computer screen following a search shall be a list of all facilities identified by the search. For all of the facilities listed, the consumer guide shall present the user with summarized comparative measures and electronic links to definitions and descriptions of the measures. The guide shall include a feature that allows the user to choose the particular comparative measures that will be displayed on the screen. The guide also may include a consumer needs assessment function to assist the user in choosing measures. The comparative measures shall be derived from the following sources:

(1) The aggregate responses made by a facility's residents or their families to measures of customer satisfaction included in the surveys conducted under section 173.54 of the Revised Code. The measures shall be specified in rules adopted under section 173.57 of the Revised Code. For each measure, the guide shall compare the responses for the facility to the statewide average or to a peer-group average specified in rule under section 173.57 of the Revised Code.

(2) The scores on clinical quality indicators calculated under section 173.56 of the Revised Code. The indicators shall be specified in rules adopted under section 173.57 of the Revised Code. For each indicator, the guide shall compare the facility's score to the statewide average or to a peer-group average specified in rule under section 173.57 of the Revised Code. The scores shall be expressed as percentages.

(3) All of the following:

(a) The date of the facility's most recent standard survey;

(b) The percentage of specified survey data tags for which the facility was found to be in compliance during the facility's most recent standard survey. The department of aging shall specify in rule the survey data tags used for this purpose and may exclude tags that are never or very rarely cited during surveys.

(c) The statewide average percentage of the specified survey data tags for which facilities were found to be in compliance during the most recent standard surveys. Alternatively, the department of aging may prescribe by rule that a peer-group average be used.

(d) The number of specified survey data tags cited by the department of health in the facility's most recent standard survey;

(e) The statewide average number of specified survey data tags cited by the department of health during the most recent standard surveys. Alternatively, the department of aging may prescribe by rule that a peer-group average be used.

(f) The date the facility achieved substantial compliance with medicare and medicaid certification requirements;

(g) Whether the department of health determined that the facility provided substandard care to residents during two of its last three standard surveys;

(h) Whether the department of health found that the care provided by the facility placed residents in immediate jeopardy during two of its last three standard surveys.

(4) An electronic link for each facility on the list allowing the user to gain access to information on the facility maintained under division (D) of this section.

(D) In addition to the summarized information provided by the guide pursuant to division (C) of this section, the guide shall provide specific comparative information on each nursing facility. When the guide's user opens an electronic link to the specific information, the first information to appear on the computer screen shall include all of the following:

(1) The name of the facility and its owner, the facility's telephone number and address, including the county in which the facility is located. The guide shall include a function that pinpoints on a map the facility's location.

(2) The facility's status with regard to medicare and medicaid certification and private accreditation;

(3) The number of beds in the facility;

(4) An electronic link allowing the user of the guide to gain access to a listing of services provided by the facility. The listing shall be presented in the format specified in rules adopted under section 173.57 of the Revised Code.

(5) At the facility's option, a picture of the facility, a brief statement provided by the facility, and an electronic link to any information the facility maintains about itself on the internet;

(6) The summarized information specified in division (C) of this section for the facility, with electronic links allowing the user to gain access to additional information presented as follows:

(a) For each statistically valid and reliable question asked on the questionnaires used in the resident and family surveys conducted under section 173.54 of the Revised Code, the guide shall present the customer

satisfaction responses. The responses for the facility shall be compared to the statewide average or to a peer-group average specified in rule under section 173.57 of the Revised Code and shall be expressed in percentages.

(b) For each clinical quality indicator calculated under section 173.56 of the Revised Code, the guide shall present the facility's score compared to the statewide average score. The scores shall be expressed as percentages.

(c) The guide shall present a list of all survey data tags that were cited during the facility's most recent standard survey, a brief description pertaining to each data tag, directions or electronic links for obtaining more information about the facility's survey history, and links to the text of each citation and to the facility's plan of correction filed with the state for each citation.

(7) Any other information, which may include information about staffing, the department of aging prescribes by rule.

Sec. 173.52. (A) The department of aging shall update information in the Ohio long-term care consumer guide as follows:

(1) The customer satisfaction data obtained under section 173.54 of the Revised Code shall be updated annually following the surveys conducted under that section.

(2) The clinical quality indicator data obtained under section 173.56 of the Revised Code shall be updated in January, April, July, and October of each year, using the most recent resident assessment data available to the department.

(3) The data derived from standard surveys of each nursing facility, as specified in division (C)(3) of section 173.51 of the Revised Code, shall be updated weekly, using the most recent standard survey data available to the department. The department shall modify the data included in the consumer guide to reflect either of the following:

(a) Any change in the survey data resulting from informal dispute resolution, appeal, or any other process;

(b) The date of correction of any citation.

(4) Any other information specified in sections 173.45 to 173.59 of the Revised Code or the rules adopted under section 173.57 of the Revised Code shall be updated at the time specified in those sections or the rules.

(B) The department of aging shall specify by rule information in the guide that nursing facilities can electronically update without the need for any action by the department, which shall include any information that the facility originally submitted to the department. The guide shall include a mechanism for such updates. This division does not apply to information described in divisions (A)(1), (2), and (3) of this section.

(C) The department of health shall cooperate with the department of aging to ensure that standard survey information and quality indicator data are updated in accordance with this section, subject to the regulatory requirements, procedures, and guidelines of the United States health care financing administration.

Sec. 173.53. In addition to the computerized Ohio long-term care consumer guide, the department of aging shall prepare and make available to the public printed information to assist consumers in making long-term care and nursing facility placement decisions, particularly consumers who do not have access to the internet. The printed information shall specify organizations that will provide consumers free on-site access to the consumer guide and will mail to consumers free paper copies of electronic pages of the guide.

Sec. 173.54. (A) Through the contract required under section 173.47 of the Revised Code, the department of aging shall provide for customer satisfaction surveys for use in publishing the Ohio long-term care consumer guide. The department shall ensure that the customer satisfaction surveys are conducted as follows:

(1) The surveys shall be conducted annually.

(2) The surveys shall consist of standardized, statistically valid and reliable questionnaires for nursing facility residents and for families of nursing facility residents. Each questionnaire shall be structured in a manner that produces statistically tested valid and reliable responses, as specified in rules adopted by the department. Each questionnaire shall ask the resident's age and gender. The resident questionnaire shall ask who, if anyone, assisted the resident in completing the questionnaire. The family questionnaire shall ask the relationship of the person completing the questionnaire to the resident.

(3) The resident survey shall be conducted in person, using a standardized survey protocol developed by the department in consultation with the long-term care consumer guide advisory council. The survey shall be conducted in a manner designed to preserve the resident's confidentiality as much as possible.

(4) The family survey shall be conducted using anonymous questionnaires distributed to families and returned to a person other than the nursing facility, in accordance with a standardized survey protocol developed by the department in consultation with the long-term care consumer guide advisory council.

(B) In addition to being used for the consumer guide, the results of the surveys conducted under this section shall be provided to the nursing

facilities to which they pertain. Each nursing facility in this state shall participate as necessary for successful completion of the surveys.

Sec. 173.55. The department of aging may charge a fee, not to exceed four hundred dollars, for each of the annual customer satisfaction surveys conducted under section 173.54 of the Revised Code. The fee shall be paid by the nursing facility and is subject to reimbursement through the medicaid program pursuant to sections 5111.20 to 5111.32 of the Revised Code.

All fees collected under this section shall be deposited to the credit of the long-term care consumer guide fund, which is hereby created in the state treasury. The fund shall be used for costs associated with publishing the Ohio long-term care consumer guide, including the cost of contracting with persons and government entities under section 173.47 of the Revised Code. The department may contract with a person or government entity to collect the fees on behalf of the department.

Sec. 173.56. For purposes of the long-term care consumer guide, the department of aging shall use, subject to federal regulatory requirements, procedures, and guidelines, the clinical quality indicators calculated for each nursing facility by the United States health care financing administration for the purposes of the medicare and medicaid programs.

Sec. 173.57. (A) The department of aging shall adopt rules to implement and administer sections 173.45 to 173.59 of the Revised Code. The rules shall specify all of the following:

(1) The content of the Ohio long-term care consumer guide, including any information in addition to the information specified in section 173.51 of the Revised Code;

(2) The content of the computerized and printed forms of the executive summary of the consumer guide;

(3) The customer satisfaction measures to be published in the consumer guide pursuant to division (C)(1) of section 173.51 of the Revised Code;

(4) The clinical quality indicators to be published in the consumer guide pursuant to division (C)(2) of section 173.51 of the Revised Code;

(5) For purposes of clinical quality, customer satisfaction, and survey data tag comparisons under section 173.51 of the Revised Code, criteria to be used in classifying nursing facilities into peer groups, which may be based on case-mix scores calculated under section 5111.231 of the Revised Code, the size of nursing facilities, the location of facilities, or other pertinent factors;

(6) The format for listing nursing facility services in the consumer guide and the manner in which that information is to be collected from nursing facilities;

(7) A method of including additional long-term care facilities and service providers in the consumer guide pursuant to considerations made under division (B)(4) of section 173.58 of the Revised Code;

(8) Any other requirements necessary to implement and administer sections 173.45 to 173.59 of the Revised Code.

(B) The department shall develop rules under this section in consultation with the long-term care consumer guide advisory council created under section 173.58 of the Revised Code. Before filing a rule under section 119.03 of the Revised Code, the department shall present it to the advisory council and provide the council a reasonable time to comment on it. The department shall give appropriate consideration to recommendations of the advisory council regarding proposed rules.

(C) All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code. Initial rules shall be adopted not later than six months after the effective date of this section.

Sec. 173.58. (A) There is hereby created the long-term care consumer guide advisory council. The council shall be convened by the director of aging and shall consist of the following members:

(1) A representative of the department of aging, appointed by the director of aging;

(2) A representative of the department of health, appointed by the director of health;

(3) A representative of the department of job and family services, appointed by the director of job and family services;

(4) The state long-term care ombudsperson;

(5) A family member of a nursing facility resident, appointed by the governor;

(6) A representative of the Ohio association of area agencies on aging, appointed by the president of the association;

(7) Two representatives of the Ohio health care association, appointed by the chief administrator of the association;

(8) Two representatives of the association of Ohio philanthropic homes, housing, and services for the aging, appointed by the chief administrator of the association;

(9) Two representatives of the Ohio academy of nursing homes, appointed by the chief administrator of the academy;

(10) A representative of the Ohio association of regional long-term care ombudsmen, appointed by the chief administrator of the association;

(11) A representative of the Ohio chapter of the American association of retired persons, appointed by the chief administrator of the chapter;

(12) A representative of a consumer group or other not-for-profit entity that is organized for the purpose of promoting improved care for nursing home residents, appointed by the governor;

(13) A representative of a research organization, appointed by the chief administrator of the organization. The research organization represented shall be selected by the director of aging from among research organizations in this state that have experience in long-term care policy matters.

Each council member shall serve at the discretion of the authority that appointed the member. Each member shall serve without compensation or reimbursement for expenses, except to the extent that serving as a member of the council is part of the member's regular duties of employment.

The member serving as the representative of the department of aging shall serve as the council's chairperson. The department shall supply meeting space and staff support for the council.

(B) The council's duties include all of the following:

(1) To help develop and review rules to be adopted by the department of aging under section 173.57 of the Revised Code;

(2) To recommend administrative practices to the department for improving the operation and content of the Ohio long-term care consumer guide;

(3) To recommend legislative changes to the department needed to improve the consumer guide;

(4) To consider whether it is feasible to include in the consumer guide other long-term care facilities, such as residential care facilities and intermediate care facilities for the mentally retarded, and long-term care service providers, such as home health agencies and adult day service providers;

(5) To consider whether it is feasible to include in the consumer guide measurements of quality of life standards.

(C) The long-term care consumer guide advisory council is not subject to section 101.84 of the Revised Code.

Sec. 173.59. (A) The department of aging shall include no advertising in the Ohio long-term care consumer guide that shall cause a conflict of interest.

(B) This section does not affect information included in the Ohio long-term care consumer guide under division (D)(5) of section 173.51 of the Revised Code.

Sec. 3702.525. (A) Not later than twenty-four months after the date the director of health mails the notice that the certificate of need has been granted or, if the grant or denial of the certificate of need is appealed under

section 3702.60 of the Revised Code, not later than twenty-four months after issuance of an order granting the certificate that is not subject to further appeal, each person holding a certificate of need granted on or after ~~the effective date of this section~~ APRIL 20, 1995, shall:

(1) If the project for which the certificate of need was granted primarily involves construction and is to be financed primarily through external borrowing of funds, secure financial commitment for the stated purpose of developing the project and commence construction that continues uninterrupted except for interruptions or delays that are unavoidable due to reasons beyond the person's control, including labor strikes, natural disasters, material shortages, or comparable events;

(2) If the project for which the certificate of need was granted primarily involves construction and is to be financed primarily internally, receive formal approval from the holder's board of directors or trustees or other governing authority to commit specified funds for implementation of the project and commence construction that continues uninterrupted except for interruptions or delays that are unavoidable due to reasons beyond the person's control, including labor strikes, natural disasters, material shortages, or comparable events;

(3) If the project for which the certificate of need was granted primarily involves acquisition of medical equipment, enter into a contract to purchase or lease the equipment and to accept the equipment at the site for which the certificate was granted;

(4) If the project for which the certificate of need was granted involves no capital expenditure or only minor renovations to existing structures, provide the health service or activity by the means specified in the approved application for the certificate;

(5) If the project for which the certificate of need was granted primarily involves leasing a building or space that requires only minor renovations to the existing space, execute a lease and provide the health service or activity by the means specified in the approved application for the certificate;

(6) If the project for which the certificate of need was granted primarily involves leasing a building or space that has not been constructed or requires substantial renovations to existing space, commence construction for the purpose of implementing the reviewable activity that continues uninterrupted except for interruptions or delays that are unavoidable due to reasons beyond the person's control, including labor strikes, natural disasters, material shortages, or comparable events.

(B) The twenty-four-month period specified in division (A) of this section shall not be extended by any means, including the transfer of a

certificate of need under division (C) of section 3702.524 of the Revised Code or granting of a subsequent or replacement certificate of need. Each person holding a certificate of need granted on or after ~~the effective date of this section~~ APRIL 20, 1995, shall provide the director of health documentation of compliance with that division not later than the earlier of thirty days after complying with that division or five days after the twenty-four-month period expires. Not later than the earlier of fifteen days after ~~he receives~~ receiving the documentation or fifteen days after the twenty-four-month period expires, the director shall send by certified mail a notice to the holder of the certificate of need specifying whether the holder has complied with division (A) of this section.

(C) Notwithstanding division (B) of this section, the twenty-four-month period specified in division (A) of this section shall be extended for an additional twenty-four months for any certificate of need granted for the purchase and relocation of licensed nursing home beds on February 26, 1999.

(D) A certificate of need granted on or after ~~the effective date of this section~~ APRIL 20, 1995, expires, regardless of whether the director sends a notice under division (B) of this section, if the holder fails to comply with division (A) or (C) of this section or to provide information under division (B) of this section as necessary for the director to determine compliance.

Sec. 3721.026. (A) As used in this section and section 3721.027 of the Revised Code, "nursing facility" and "survey" have the same meanings as in section 5111.35 of the Revised Code.

(B) The director of health shall establish a unit within the department of health to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes. The director shall assign to the unit employees who have training or experience in conducting or supervising surveys, but employees assigned to the unit shall not conduct surveys. The director shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section and shall consult with interested parties in developing the rules. Technical assistance reports are not public records under section 149.43 of the Revised Code and shall not be distributed to any person outside the unit except:

(1) The nursing facility that is provided with the technical assistance;

(2) Persons charged with inspecting nursing facilities under section 3721.02 of the Revised Code or with conducting surveys or reviews of nursing facilities under section 3721.022 of the Revised Code whenever any such person finds that there is serious harm to resident health or safety that is more than isolated at the nursing facility.

The provisions of this section and rules adopted under this section do not affect the department's authority to administer and enforce other sections of this chapter.

(C) On or before the last day of December each year, the director shall submit a report to the governor and the general assembly describing the unit's activities that year and its effectiveness in improving resident outcomes.

Sec. 3721.027. The department of health shall investigate within ten working days after referral, in accordance with procedures and criteria to be established by the department of health and the department of aging, any unresolved complaint that the office of the state long-term care ombudsperson has investigated and found to be valid and refers to the department of health. This requirement does not supersede federal requirements for survey agency complaint investigations.

Sec. 3721.21. As used in sections 3721.21 to 3721.34 of the Revised Code:

(A) "Long-term care facility" means either of the following:

(1) A nursing home as defined in section 3721.01 of the Revised Code, other than a nursing home or part of a nursing home certified as an intermediate care facility for the mentally retarded under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(2) A facility or part of a facility that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act."

(B) "Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

(C) "Abuse" means knowingly causing physical harm or recklessly causing serious physical harm to a resident by physical contact with the resident or by use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in amounts that preclude habilitation and treatment.

(D) "Neglect" means recklessly failing to provide a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. "Neglect" does not include allowing a resident, at the resident's option, to receive only treatment by spiritual means through prayer in accordance with the tenets of a recognized religious denomination.

(E) "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of a resident by any means prohibited by the Revised Code, including violations of Chapter 2911. or 2913. of the

Revised Code.

(F) "Resident" includes a resident, patient, former resident or patient, or deceased resident or patient of a long-term care facility or a residential care facility.

(G) "Physical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(H) "Chemical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(I) "Nursing and nursing-related services" means the personal care services and other services not constituting skilled nursing care that are specified in rules the public health council shall adopt in accordance with Chapter 119. of the Revised Code.

(J) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code.

(K) "Nurse aide" means an individual, other than a licensed health professional practicing within the scope of the professional's license, who provides nursing and nursing-related services to residents in a long-term care facility, either as a member of the staff of the facility for monetary compensation or as a volunteer without monetary compensation.

(L) "Licensed health professional" means all of the following:

(1) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(2) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(3) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;

(4) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(5) A registered nurse or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(6) A social worker or independent social worker licensed under Chapter 4757. of the Revised Code or a social work assistant registered under that chapter;

(7) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(8) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(9) An optometrist licensed under Chapter 4725. of the Revised Code;

(10) A pharmacist licensed under Chapter 4729. of the Revised Code;

(11) A psychologist licensed under Chapter 4732. of the Revised Code;

(12) A chiropractor licensed under Chapter 4734. of the Revised Code;

(13) A nursing home administrator licensed or temporarily licensed under Chapter 4751. of the Revised Code;

(14) A professional counselor or professional clinical counselor licensed under Chapter 4757. of the Revised Code.

(M) "Competency evaluation program" means a program through which the competency of a nurse aide to provide nursing and nursing-related services is evaluated.

(N) "Training and competency evaluation program" means a program of nurse aide training and evaluation of competency to provide nursing and nursing-related services.

Sec. 5111.20. As used in sections 5111.20 to 5111.32 of the Revised Code:

(A) "Allowable costs" are those costs determined by the department of job and family services to be reasonable and do not include fines paid under sections 5111.35 to 5111.61 and section 5111.99 of the Revised Code.

(B) "Capital costs" means costs of ownership and nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements that are not approved as nonextensive renovations under section 5111.25 or 5111.251 of the Revised Code;

(iii) Equipment;

(iv) Extensive renovations;

(v) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided in division (I) of this section, lease and rent of land, building, and equipment.

The costs of capital assets of less than five hundred dollars per item may be considered costs of ownership in accordance with a provider's practice.

(2) "Costs of nonextensive renovation" means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.

(C) "Capital lease" and "operating lease" shall be construed in

rdance with generally accepted accounting principles.

(D) "Case-mix score" means the measure determined under section 5111.231 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a resident of a nursing facility or intermediate care facility for the mentally retarded.

(E) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds under section 5123.19 of the Revised Code. For a facility originally licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

(1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

(2) If a facility adds nursing home beds or residential facility beds or extensively renovates all or part of the facility after its original date of licensure, it will have a different date of licensure for the additional beds or extensively renovated portion of the facility, unless the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time.

(F) "Desk-reviewed" means that costs as reported on a cost report submitted under section 5111.26 of the Revised Code have been subjected to a desk review under division (A) of section 5111.27 of the Revised Code and preliminarily determined to be allowable costs.

(G) "Direct care costs" means all of the following:

(1)(a) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the facility;

(b) Costs for direct care staff, administrative nursing staff, medical directors, social services staff, activities staff, psychologists and psychology assistants, social workers and counselors, habilitation staff, qualified mental retardation professionals, program directors, respiratory therapists, habilitation supervisors, and except as provided in division (G)(2) of this section, other persons holding degrees qualifying them to provide therapy;

(c) Costs of purchased nursing services;

(d) Costs of quality assurance;

(e) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, for personnel listed in divisions (G)(1)(a), (b), and (d) of this section;

(f) Costs of consulting and management fees related to direct care;

(g) Allocated direct care home office costs.

(2) In addition to the costs specified in division (G)(1) of this section, for intermediate care facilities for the mentally retarded only, direct care costs include both of the following:

(a) Costs for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech therapists, and audiologists;

(b) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, for personnel listed in division (G)(2)(a) of this section.

(3) Costs of other direct-care resources that are specified as direct care costs in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code.

(H) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(I) "Indirect care costs" means all reasonable costs other than direct care costs, other protected costs, or capital costs. "Indirect care costs" includes but is not limited to costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, consumer satisfaction survey fees paid under section 173.55 of the Revised Code, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family

services in accordance with Chapter 119. of the Revised Code, for personnel listed in this division. Notwithstanding division (B)(1) of this section, "indirect care costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(J) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a nursing facility or intermediate care facility for the mentally retarded that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 Stat. 610 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(K) "Intermediate care facility for the mentally retarded" means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."

(L) "Maintenance and repair expenses" means, except as provided in division (X)(2) of this section, expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the cost of ordinary repairs such as painting and wallpapering.

(M) "Nursing facility" means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded. "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XVIII of the "Social Security Act."

(N) "Other protected costs" means costs for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs defined as other protected costs in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code.

(O) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any

ombination, in a nursing facility or intermediate care facility for the mentally retarded.

(P) "Patient" includes "resident."

(Q) Except as provided in divisions (Q)(1) and (2) of this section, "per diem" means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that cost reporting period.

(1) When calculating indirect care costs for the purpose of establishing rates under section 5111.24 or 5111.241 of the Revised Code, "per diem" means a facility's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.

(2) When calculating capital costs for the purpose of establishing rates under section 5111.25 or 5111.251 of the Revised Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(R) "Provider" means a person or government entity that operates a nursing facility or intermediate care facility for the mentally retarded under a provider agreement.

(S) "Provider agreement" means a contract between the department of job and family services and a nursing facility or intermediate care facility for the mentally retarded for the provision of nursing facility services or intermediate care facility services for the mentally retarded under the medical assistance program.

(T) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse aides who are not employees of the facility.

(U) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(V) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider.

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met:

(a) The supplier is a separate bona fide organization.

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes.

(c) The types of goods or services are commonly obtained by other nursing facilities or intermediate care facilities for the mentally retarded from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities.

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(W) "Relative of owner" means an individual who is related to an owner of a nursing facility or intermediate care facility for the mentally retarded by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Step-parent, step-child, step-brother, or step-sister;

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

(6) Grandparent or grandchild;

(7) Foster parent, foster child, foster brother, or foster sister.

(X) "Renovation" and "extensive renovation" mean:

(1) Any betterment, improvement, or restoration of a nursing facility or

intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules adopted by the director of job and family services in effect on December 22, 1992.

(2) In the case of betterments, improvements, and restorations of nursing facilities and intermediate care facilities for the mentally retarded started on or after July 1, 1993:

(a) "Renovation" means the betterment, improvement, or restoration of a nursing facility or intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. "Renovation" does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity.

(b) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years.

For the purposes of division (X)(2) of this section, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for the estimated rate of inflation from January 1, 1993, to the end of the calendar year during which the renovation is completed, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

The department of job and family services may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if the department determines that the renovation is more prudent than construction of new beds.

Sec. 5111.25. (A) The department of job and family services shall pay each eligible nursing facility a per resident per day rate for its reasonable capital costs established prospectively each fiscal year for each facility. Except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code, the rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of divisions (A)(1) to (3) of this section:

(1) The lesser of the following:

(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership and eighty-five per cent of the facility's actual, allowable, per diem cost of nonextensive renovation determined under division (F) of this section;

(b) Eighty-eight and sixty-five one-hundredths per cent of the following limitation:

(i) For the fiscal year beginning July 1, 1993, sixteen dollars per resident day;

(ii) For the fiscal year beginning July 1, 1994, sixteen dollars per resident day, adjusted to reflect the rate of inflation for the twelve-month period beginning July 1, 1992, and ending June 30, 1993, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics;

(iii) For subsequent fiscal years, the limitation in effect during the previous fiscal year, adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) Any efficiency incentive determined under division (D) of this section;

(3) Any amounts for return on equity determined under division (H) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules adopted under this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in cost of ownership or renovation unless that part of the payment under sections 5111.20 to 5111.32 of the Revised Code is used to reimburse the government agency.

(B) The capital cost basis of nursing facility assets shall be determined in the following manner:

(1) For purposes of calculating the rate to be paid for the fiscal year

beginning July 1, 1993, for facilities with dates of licensure on or before June 30, 1993, the capital cost basis shall be equal to the following:

(a) For facilities that have not had a change of ownership during the period beginning January 1, 1993, and ending June 30, 1993, the desk-reviewed, actual, allowable capital cost basis that is listed on the facility's cost report for the cost reporting period ending December 31, 1992, plus the actual, allowable capital cost basis of any assets constructed or acquired after December 31, 1992, but before July 1, 1993, if the aggregate capital costs of those assets would increase the facility's rate for capital costs by twenty or more cents per resident per day.

(b) For facilities that have a date of licensure or had a change of ownership during the period beginning January 1, 1993, and ending June 30, 1993, the actual, allowable capital cost basis of the person or government entity that owns the facility on June 30, 1993.

Capital cost basis shall be calculated as provided in division (B)(1) of this section subject to approval by the United States health care financing administration of any necessary amendment to the state plan for providing medical assistance.

The department shall include the actual, allowable capital cost basis of assets constructed or acquired during the period beginning January 1, 1993, and ending June 30, 1993, in the calculation for the facility's rate effective July 1, 1993, if the aggregate capital costs of the assets would increase the facility's rate by twenty or more cents per resident per day and the facility provides the department with sufficient documentation of the costs before June 1, 1993. If the facility provides the documentation after that date, the department shall adjust the facility's rate to reflect the costs of the assets one month after the first day of the month after the department receives the documentation.

(2) Except as provided in division (B)(4) of this section, for purposes of calculating the rates to be paid for fiscal years beginning after June 30, 1994, for facilities with dates of licensure on or before June 30, 1993, the capital cost basis of each asset shall be equal to the desk-reviewed, actual, allowable, capital cost basis that is listed on the facility's cost report for the calendar year preceding the fiscal year during which the rate will be paid.

(3) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code.

(4) Except as provided in division (B)(5) of this section, if a provider

transfers an interest in a facility to another provider after June 30, 1993, there shall be no increase in the capital cost basis of the asset if the providers are related parties. If the providers are not related parties or if they are related parties and division (B)(5) of this section requires the adjustment of the capital cost basis under this division, the basis of the asset shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time that the transferor held the asset, as calculated by the department of job and family services using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time that the transferor held the asset.

(5) If a provider transfers an interest in a facility to another provider who is a related party, the capital cost basis of the asset shall be adjusted as specified in division (B)(4) of this section for a transfer to a provider that is not a related party if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) ~~The~~ Except as provided in division (B)(5)(c)(ii) of this section, the provider making the transfer retains no ownership interest in the facility;

(c) The ~~United States internal revenue service has issued a ruling~~ department of job and family services determines that the transfer is an arm's length transaction ~~for purposes of federal income taxation;~~ pursuant to rules the department shall adopt in accordance with Chapter 119. of the Revised Code no later than December 31, 2000. The rules shall provide that a transfer is an arm's length transaction if all of the following apply:

(i) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(ii) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The transfer satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted

most recently under division (B)(5) of this section or actual, allowable cost of ownership was determined most recently under division (C)(9) of this section.

(C) As used in this division, "lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease. As used in this division, "new lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

(1) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility that was effective on May 27, 1992, the entire lease expense is an actual, allowable cost of ownership during the term of the existing lease. The entire lease expense also is an actual, allowable cost of ownership if a lease in existence on May 27, 1992, is renewed under either of the following circumstances:

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992;

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992.

(2) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by the lesser of the following amounts:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(3) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that is initially operated under a lease, actual, allowable cost of ownership shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable cost of

ownership shall include the lesser of the annual lease expense or the sum of the following:

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis;

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or the imputed interest expense calculated at the inception of the lease using seventy per cent of the lessor's historical capital asset cost basis.

(4) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable cost of ownership shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of the lessor, adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(5) Subject to the limitation specified in division (A)(1) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

(6) Subject to the limitation specified in division (A)(1) of this section,

for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (C)(2), (3), (4), or (6) of this section, as applicable. If the old lease was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be adjusted by the lesser of the following for purposes of calculating the annual amount under division (C)(2), (3), (4), or (6) of this section:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

In the case of a lease under division (C)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount.

(7) For any revision of a lease described in division (C)(1), (2), (3), (4), (5), or (6) of this section, or for any subsequent lease of a facility operated under such a lease, other than execution of a new lease, the portion of actual, allowable cost of ownership attributable to the lease shall be the same as before the revision or subsequent lease.

(8) Except as provided in division (C)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party, the related party's actual, allowable cost of ownership shall include the lesser of the annual lease expense or the reasonable cost to the lessor.

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable cost of ownership shall include the annual lease expense, subject to the limitations specified in divisions (C)(1) to (7) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) If the lessor retains an ownership interest, it is, except as provided in division (C)(9)(c)(ii) of this section, in only the real property and any improvements on the real property;

(c) The ~~United States internal revenue service has issued a ruling~~ department of job and family services determines that the lease is an arm's

length transaction ~~for purposes of federal income taxation;~~ pursuant to rules the department shall adopt in accordance with Chapter 119. of the Revised Code no later than December 31, 2000. The rules shall provide that a lease is an arm's length transaction if all of the following apply:

(i) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (C)(9)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The lease satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (B)(5) of this section or actual, allowable cost of ownership was determined most recently under division (C)(9) of this section.

(10) This division does not apply to leases of specific items of equipment.

(D)(1) Subject to division (D)(2) of this section, the department shall pay each nursing facility an efficiency incentive that is equal to fifty per cent of the difference between the following:

(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership;

(b) The applicable amount specified in division (E) of this section.

(2) The efficiency incentive paid to a nursing facility shall not exceed the greater of the following:

(a) The efficiency incentive the facility was paid during the fiscal year ending June 30, 1994;

(b) Three dollars per resident per day, adjusted annually for rates paid beginning July 1, 1994, for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(3) For purposes of calculating the efficiency incentive, depreciation for costs that are paid or reimbursed by any government agency shall be considered as costs of ownership, and renovation costs that are paid under division (F) of this section shall not be considered costs of ownership.

(E) The following amounts shall be used to calculate efficiency incentives for nursing facilities under this section:

(1) For facilities with dates of licensure prior to January 1, 1958, four dollars and twenty-four cents per patient day;

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968:

(a) Five dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Four dollars and twenty-four cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976:

(a) Six dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Five dollars and twenty-four cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeded three thousand five hundred dollars per bed;

(c) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979:

(a) Seven dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;

(b) Six dollars and twenty-four cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeded five thousand one hundred fifty dollars per bed;

(c) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeded three thousand five hundred dollars per bed;

(d) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1981:

(a) Seven dollars and seventy-four cents per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;

(b) Seven dollars and twenty-four cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeded six thousand eight hundred dollars per bed;

(c) Six dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeded five thousand one hundred fifty dollars per bed;

(d) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeded three thousand five hundred dollars per bed;

(e) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure in 1981 or any year thereafter prior to December 22, 1992, the following amount:

(a) For facilities with construction costs less than seven thousand six hundred twenty-five dollars per bed, the applicable amounts for the construction costs specified in divisions (E)(5)(b) to (e) of this section;

(b) For facilities with construction costs of seven thousand six hundred twenty-five dollars or more per bed, six dollars per patient day, provided that for 1981 and annually thereafter prior to December 22, 1992, department shall do both of the following to the six-dollar amount:

(i) Adjust the amount for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, using 1980 as the base year;

(ii) Increase the amount, as adjusted for inflation under division (E)(6)(b)(i) of this section, by one dollar and seventy-four cents.

(7) For facilities with dates of licensure on or after January 1, 1992, seven dollars and ninety-seven cents, adjusted for fluctuations in construction costs between 1991 and 1993 as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, and then increased by one dollar and seventy-four cents.

For the fiscal year that begins July 1, 1994, each of the amounts listed in divisions (E)(1) to (7) of this section shall be increased by twenty-five cents. For the fiscal year that begins July 1, 1995, each of those amounts shall be increased by an additional twenty-five cents. For subsequent fiscal years, each of those amounts, as increased for the prior fiscal year, shall be adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day

of June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

If the amount established for a nursing facility under this division is less than the amount that applied to the facility under division (B) of former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the amount used to calculate the efficiency incentive for the facility under division (D)(2) of this section shall be the amount that was calculated under division (B) of the former section.

(F) Beginning July 1, 1993, regardless of the facility's date of licensure or the date of the nonextensive renovations, the rate for the costs of nonextensive renovations for nursing facilities shall be eighty-five per cent of the desk-reviewed, actual, allowable, per diem, nonextensive renovation costs. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made nonextensive renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

(1) For a nonextensive renovation made after July 1, 1993, to qualify for payment under this division, both of the following conditions must be met:

(a) At least five years have elapsed since the date of licensure of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(b) The provider has obtained prior approval from the department of job and family services, and if required the director of health has granted a certificate of need for the renovation under section 3702.52 of the Revised Code. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The department of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of job and family services unless the increase in scope is approved by the department.

(2) The payment provided for in this division is the only payment that shall be made for the costs of a nonextensive renovation. Nonextensive

renovation costs shall not be included in costs of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of calculating the efficiency incentive under divisions (D) and (E) of this section.

(G) The owner of a nursing facility operating under a provider agreement shall provide written notice to the department of job and family services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program. After the date on which a transaction of sale is closed, the owner shall refund to the department the amount of excess depreciation paid to the facility by the department for each year the owner has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the facility has received payment. If a nursing facility is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If a nursing facility is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the difference between ten and the number of years that the facility was operated under a provider agreement. If a nursing facility is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department. The owner of a facility that is sold or that voluntarily terminates participation in the medical assistance program also shall refund any other amount that the department properly finds to be due after the audit conducted under this division. For the purposes of this division, "depreciation paid to the facility" means the amount paid to the nursing facility for cost of ownership pursuant to this section less any amount paid for interest costs, amortization of financing costs, and lease expenses. For the purposes of this division, "excess depreciation" is the nursing facility's depreciated basis, which is the owner's cost less accumulated depreciation, subtracted from the purchase price net of selling costs but not exceeding the amount of depreciation paid to the facility.

A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The amount of the last two monthly payments to a nursing facility made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or termination of participation shall be held in escrow by a bank, trust

company, or savings and loan association, except that if the amount the owner will be required to refund under this section is likely to be less than the amount of the last two monthly payments, the department shall take one of the following actions instead of withholding the amount of the last two monthly payments:

(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount sufficient to cover the amount likely to be refunded;

(2) In the case of all other owners, withhold the amount of the last monthly payment to the nursing facility.

The department shall, within ninety days following the filing of the cost report, audit the cost report and issue an audit report to the owner. The department also may audit any other cost report that the facility has filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the nursing facility. The findings shall be subject to adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate stock, the merger of one corporation into another, or a consolidation does not constitute a sale.

If a nursing facility is not sold or its participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination. After written notice is received from a nursing facility that a sale or termination will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.

(H) The department shall pay each eligible proprietary nursing facility a return on the facility's net equity computed at the rate of one and one-half times the average interest rate on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period, except that no facility's return on net equity shall exceed one dollar

per patient day.

When calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(I) If a nursing facility would receive a lower rate for capital costs for assets in the facility's possession on July 1, 1993, under this section than it would receive under former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the facility shall receive for those assets the rate it would have received under the former section for each fiscal year beginning on or after July 1, 1993, until the rate it would receive under this section exceeds the rate it would have received under the former section. Any facility that receives a rate calculated under the former section 5111.25 of the Revised Code for assets in the facility's possession on July 1, 1993, also shall receive a rate calculated under this section for costs of any assets it constructs or acquires after July 1, 1993.

Sec. 5111.251. (A) The department of job and family services shall pay each eligible intermediate care facility for the mentally retarded for its reasonable capital costs, a per resident per day rate established prospectively each fiscal year for each intermediate care facility for the mentally retarded. Except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code, the rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of the following:

(1) The facility's desk-reviewed, actual, allowable, per diem cost of ownership for the preceding cost reporting period, limited as provided in divisions (C) and (F) of this section;

(2) Any efficiency incentive determined under division (B) of this section;

(3) Any amounts for renovations determined under division (D) of this section;

(4) Any amounts for return on equity determined under division (I) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight line method over a period designated by the director of job and family services in rules adopted in accordance with Chapter 119. of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period

approved by the department of job and family services. Any rules adopted under this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in costs of ownership or renovation unless that part of the payment under sections 5111.20 to 5111.32 of the Revised Code is used to reimburse the government agency.

(B) The department of job and family services shall pay to each intermediate care facility for the mentally retarded an efficiency incentive equal to fifty per cent of the difference between any desk-reviewed, actual, allowable cost of ownership and the applicable limit on cost of ownership payments under division (C) of this section. For purposes of computing the efficiency incentive, depreciation for costs paid or reimbursed by any government agency shall be considered as a cost of ownership, and the applicable limit under division (C) of this section shall apply both to facilities with more than eight beds and facilities with eight or fewer beds. The efficiency incentive paid to a facility with eight or fewer beds shall not exceed three dollars per patient day, adjusted annually for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(C) Cost of ownership payments to intermediate care facilities for the mentally retarded with more than eight beds shall not exceed the following limits:

(1) For facilities with dates of licensure prior to January 1, l958, not exceeding two dollars and fifty cents per patient day;

(2) For facilities with dates of licensure after December 31, l957, but prior to January 1, l968, not exceeding:

(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, l967, but prior to January 1, l976, not exceeding:

(a) Four dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Three dollars and fifty cents per patient day if the cost of

construction was less than five thousand one hundred fifty dollars per bed, but exceeds three thousand five hundred dollars per bed;

(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, l975, but prior to January 1, l979, not exceeding:

(a) Five dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;

(b) Four dollars and fifty cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeds five thousand one hundred fifty dollars per bed;

(c) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeds three thousand five hundred dollars per bed;

(d) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, l978, but prior to January 1, l980, not exceeding:

(a) Six dollars per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;

(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred dollars per bed;

(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five thousand one hundred fifty dollars per bed;

(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed;

(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health.

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:

(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and twenty-three cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:

(a) Twelve dollars and fifty-three cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and forty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(12) For facilities with dates of licensure after December 31, 1985, but prior to January 1, 1987, not exceeding:

(a) Twelve dollars and seventy cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and fifty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding:

(a) Twelve dollars and ninety-nine cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and sixty-seven cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per patient day;

(15) For facilities with dates of licensure after December 31, 1988, but prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per patient day;

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per patient day;

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per patient day;

(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen dollars and sixty-seven cents per patient day;

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day.

(D) Beginning January 1, 1981, regardless of the original date of licensure, the department of job and family services shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, l981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs

has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

For a nonextensive renovation to qualify for payment under this division, both of the following conditions must be met:

(1) At least five years have elapsed since the date of licensure or date of an extensive renovation of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(2) The provider has obtained prior approval from the department of job and family services. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of job and family services unless the increase in scope is approved by the department.

(E) The amounts specified in divisions (C) and (D) of this section shall be adjusted beginning July 1, 1993, for the estimated inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which rate will be paid and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(F)(1) For facilities of eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities before July 1, 1993, and for facilities of eight or fewer beds that have dates of licensure or have been granted project authorization after that date if the facilities demonstrate that they made substantial commitments of funds on or before that date, cost of ownership shall not exceed eighteen dollars and thirty cents per resident per day. The eighteen-dollar and thirty-cent amount shall be increased by the change in the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, during the period beginning June 30, 1990, and ending July 1, 1993, and by the change in the consumer price index for shelter costs for all urban consumers for the north central region,

as published by the United States bureau of labor statistics, annually thereafter.

(2) For facilities with eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities on or after July 1, 1993, for which substantial commitments of funds were not made before that date, cost of ownership payments shall not exceed the applicable amount calculated under division (F)(1) of this section, if the department of job and family services gives prior approval for construction of the facility. If the department does not give prior approval, cost of ownership payments shall not exceed the amount specified in division (C) of this section.

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this section, the total payment for cost of ownership, cost of ownership efficiency incentive, and capitalized costs of renovations for an intermediate care facility for the mentally retarded with eight or fewer beds shall not exceed the sum of the limitations specified in divisions (C) and (D) of this section.

(G) Notwithstanding any provision of this section or section 5111.24 of the Revised Code, the director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code that provide for a calculation of a combined maximum payment limit for indirect care costs and cost of ownership for intermediate care facilities for the mentally retarded with eight or fewer beds.

(H) After June 30, 1980, the owner of an intermediate care facility for the mentally retarded operating under a provider agreement shall provide written notice to the department of job and family services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program. After the date on which a transaction of sale is closed, the owner shall refund to the department the amount of excess depreciation paid to the facility by the department for each year the owner has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the facility has received payment. If an intermediate care facility for the mentally retarded is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If an intermediate care facility for the mentally retarded is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the number of years less than ten that a facility was operated under a provider agreement. If an intermediate care

facility for the mentally retarded is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department. For the purposes of this division, "depreciation paid to the facility" means the amount paid to the intermediate care facility for the mentally retarded for cost of ownership pursuant to this section less any amount paid for interest costs. For the purposes of this division, "excess depreciation" is the intermediate care facility for the mentally retarded's depreciated basis, which is the owner's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount of depreciation paid to the facility.

A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated for an intermediate care facility for the mentally retarded subject to this division. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The amount of the last two monthly payments to an intermediate care facility for the mentally retarded made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or voluntary termination of participation shall be held in escrow by a bank, trust company, or savings and loan association, except that if the amount the owner will be required to refund under this section is likely to be less than the amount of the last two monthly payments, the department shall take one of the following actions instead of withholding the amount of the last two monthly payments:

(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount sufficient to cover the amount likely to be refunded;

(2) In the case of all other owners, withhold the amount of the last monthly payment to the intermediate care facility for the mentally retarded.

The department shall, within ninety days following the filing of the cost report, audit the report and issue an audit report to the owner. The department also may audit any other cost reports for the facility that have been filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the intermediate care facility for the mentally retarded. The findings shall be subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less

than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate stock, the merger of one corporation into another, or a consolidation does not constitute a sale.

If an intermediate care facility for the mentally retarded is not sold or its participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination of participation. After written notice is received from an intermediate care facility for the mentally retarded that a sale or termination of participation will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.

(I) The department of job and family services shall pay each eligible proprietary intermediate care facility for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day.

In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(J)(1) Except as provided in division (J)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following:

(a) The annual lease expense or actual cost of ownership, whichever is applicable;

(b) The reasonable cost to the lessor or provider making the transfer.

(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to (I) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) In the case of a lease, if the lessor retains any ownership interest, it is, except as provided in division (J)(2)(d)(ii) of this section, in only the real property and any improvements on the real property;

(c) In the case of a transfer, the provider making the transfer retains, except as provided in division (J)(2)(d)(iv) of this section, no ownership interest in the facility;

(d) The ~~United States internal revenue service has issued a ruling~~ department of job and family services determines that the lease or transfer is an arm's length transaction ~~for purposes of federal income taxation;~~ pursuant to rules the department shall adopt in accordance with Chapter 119. of the Revised Code no later than December 31, 2000. The rules shall provide that a lease or transfer is an arm's length transaction if all of the following, as applicable, apply:

(i) In the case of a lease, once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (J)(2)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) In the case of a lease, The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) In the case of a transfer, Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(iv) In the case of a transfer, the provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs.

(v) The lease or transfer satisfies any other criteria specified in the rules.

(e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, allowable cost of ownership was determined most recently under this division.

Sec. 5111.62. The proceeds of all fines, including interest, collected under sections 5111.35 to 5111.62 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund, which is hereby created. Moneys in the fund shall be used ~~solely~~ for the protection of the health or property of residents of nursing facilities in which the department of health finds deficiencies, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for the loss of money managed by the facility under section 3721.15 of the Revised Code. The fund shall be maintained and administered by the department of job and family services under rules developed in consultation with the departments of health and aging and adopted by the director of job and family services under Chapter 119. of the Revised Code.

SECTION 2. That existing sections 173.19, 3702.525, 3721.21, 5111.20, 5111.25, 5111.251, and 5111.62 of the Revised Code are hereby repealed.

SECTION 3. Notwithstanding the fourteen-month publishing deadline established in section 173.46 of the Revised Code, the Department of Aging shall not publish the Ohio Long-term Care Consumer Guide unless it includes in the guide the results of customer satisfaction surveys conducted under section 173.54 of the Revised Code. For the purposes of this condition, the department may publish the guide if it includes in the guide the results of surveys of families of nursing facility residents covering at least twenty-five per cent of the nursing facilities in this state and it has established a process for conducting both family and resident satisfaction surveys under section 173.54 of the Revised Code.

SECTION 4. All items in this section are hereby appropriated as designated out of any moneys in the state treasury to the credit of the designated fund group. For all appropriations made in this act, those in the first column are for fiscal year 2000 and those in the second column are for fiscal year 2001. The appropriations made in this act are in addition to any other appropriations made for the 1999-2001 biennium.

JFS DEPARTMENT OF JOB AND FAMILY SERVICES

General Revenue Fund

GRF 600-525	Health Care/Medicaid		
State		$ 0	$ 8,150,410

Federal		$ 0	$	11,699,590
Health Care Total		$ 0	$	19,850,000
Total GRF General Revenue Fund Group				
State		$ 0	$	8,150,410
Federal		$ 0	$	11,699,590
GRF Total		$ 0	$	19,850,000
TOTAL ALL BUDGET FUND GROUPS		$ 0	$	19,850,000

Health Care/Medicaid

Of the foregoing appropriation item 600-525, Health Care/Medicaid, $3,650,000 shall be used in fiscal year 2001 to support additional slots for the Department of Job and Family Services' Ohio Home Care Waiver Program.

DMR DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

General Revenue Fund

GRF	322-413	Residential and Support Services	$ 0	$	4,500,000
TOTAL GRF General Revenue Fund			$ 0	$	4,500,000

Federal Special Revenue Fund Group

3G6	322-639	Medicaid Waiver	$ 0	$	6,460,000
TOTAL FSR Federal Special Revenue Fund Group			$ 0	$	6,460,000
TOTAL ALL BUDGET FUND GROUPS			$ 0	$	10,960,000

Residential and Support Services

Of the foregoing appropriation item 322-413, Residential and Support Services, $4,500,000 shall be used in fiscal year 2001 as state matching funds to support additional slots for the Individual Options Home and Community-based waiver program operated pursuant to Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

Medicaid Waiver

Of the foregoing appropriation item 322-639, Medicaid Waiver (Fund 3G6), $6,460,000 shall be used in fiscal year 2001 to support additional slots for the Individual Options Home and Community-based waiver program operated pursuant to Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

AGE DEPARTMENT OF AGING

State Special Revenue Fund Group

5K9	490-613	Long-Term Care Consumer Guide	$ 0	$	807,000
TOTAL SSR State Special Revenue Fund Group			$ 0	$	807,000
TOTAL ALL BUDGET FUND GROUPS			$ 0	$	807,000

Long-Term Care Consumer Guide

Notwithstanding section 5111.62 of the Revised Code, not later than July 15, 2000, the Director of Budget and Management shall transfer

407,000 cash from Fund 4E3, Resident Protection Fund, to Fund 5K9, Long-Term Care Consumer Guide Fund.

The foregoing appropriation item 490-613, Long-Term Care Consumer Guide, shall be used by the Department of Aging for costs associated with publishing the Ohio Long-Term Care Consumer Guide.

DOH DEPARTMENT OF HEALTH

State Special Revenue Fund Group					
5L1	440-623	Nursing Facility Technical Assistance Program	$ 0	$	1,400,000
TOTAL SSR State Special Revenue Fund Group			$ 0	$	1,400,000
TOTAL ALL BUDGET FUND GROUPS			$ 0	$	1,400,000

Nursing Facility Technical Assistance Program

Notwithstanding section 5111.62 of the Revised Code, not later than July 15, 2000, the Director of Budget and Management shall transfer $1,400,000 cash from Fund 4E3, Resident Protection Fund, to Fund 5L1, Nursing Facility Technical Assistance Fund, to be used in accordance with section 3721.026 of the Revised Code.

Within the limits set forth in this act, the Director of Budget and Management shall establish accounts indicating source and amount of funds for each appropriation made in this act, and shall determine the form and manner in which appropriation accounts shall be maintained. Expenditures from appropriations contained in this act shall be accounted for as though made in Am. Sub. H.B. 283 of the 123rd General Assembly.

The appropriations made in this act are subject to all provisions of Am. Sub. H.B. 283 of the 123rd General Assembly.

SECTION 5. (A) Notwithstanding division (Q)(1) of section 5111.20 of the Revised Code, when calculating indirect care costs for the purpose of establishing rates under section 5111.24 or 5111.241 of the Revised Code for fiscal year 2001, "per diem," as used in sections 5111.20 to 5111.32 of the Revised Code, means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable indirect care costs in the cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been seventy-five per cent.

(B) Notwithstanding division (Q)(2) of section 5111.20 of the Revised Code, when calculating capital costs for the purpose of establishing rates under section 5111.25 or 5111.251 of the Revised Code for fiscal year 2001, "per diem," as used in sections 5111.20 to 5111.32 of the Revised Code, means a nursing facility's or intermediate care facility for the mentally

ded's actual, allowable capital costs in the cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.

(C) Notwithstanding section 5111.261 and division (C) of section 5111.262 of the Revised Code, for costs incurred during calendar year 1999, costs reported in a nursing facility's cost report for purchased nursing services shall be allowable direct care costs up to seventeen per cent of the nursing facility's cost specified in the cost report for services provided that year by registered nurses, licensed practical nurses, and nurse aides who are employees of the facility, plus one-half of the amount by which the reported costs for purchased nursing services exceed that percentage.

(D) As soon as practicable, the Department of Job and Family Services shall follow this section for the purpose of calculating nursing facilities' and intermediate care facilities for the mentally retarded's Medicaid reimbursement rates for indirect care and capital costs for fiscal year 2001. If the Department is unable to calculate the rates before it makes payments for services provided during fiscal year 2001, the Department shall pay a nursing facility or intermediate care facility for the mentally retarded the difference between the amount it pays the facility and the amount that would have been paid had the Department made the calculation in time.

SECTION 6. Except for sections 3702.525, 3721.21, 5111.25, and 5111.251 of the Revised Code as amended by this act, the codified and uncodified sections of law contained in this act are not subject to the referendum and take effect on the later of July 1, 2000, or the day this act becomes law. The amendments to sections 3702.525, 3721.21, 5111.25, and 5111.251 of the Revised Code made by this act constitute items of law that are subject to the referendum. Therefore, under Article II, Section 1c of the Ohio Constitution and section 1.471 of the Revised Code, these items of law take effect on the 91st day after this act is filed with the Secretary of State. If, however, a referendum petition is filed against these items of law, these items of law, unless rejected at the referendum, take effect at the earliest time permitted by law.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____