

**As Reported by the House Economic and Workforce Development
Committee**

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**Regular Session
2021-2022**

Sub. H. B. No. 461

Representative Carruthers

A BILL

To amend sections 5165.01 and 5165.15 and to enact 1
section 5165.27 of the Revised Code regarding 2
nursing facility Medicaid payments for private 3
rooms. 4

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 5165.01 and 5165.15 be amended 5
and section 5165.27 of the Revised Code be enacted to read as 6
follows: 7

Sec. 5165.01. As used in this chapter: 8

(A) "Affiliated operator" means an operator affiliated 9
with either of the following: 10

(1) The exiting operator for whom the affiliated operator 11
is to assume liability for the entire amount of the exiting 12
operator's debt under the medicaid program or the portion of the 13
debt that represents the franchise permit fee the exiting 14
operator owes; 15

(2) The entering operator involved in the change of 16
operator with the exiting operator specified in division (A) (1) 17

of this section. 18

(B) "Allowable costs" are a nursing facility's costs that 19
the department of medicaid determines are reasonable. Fines paid 20
under sections 5165.60 to 5165.89 and section 5165.99 of the 21
Revised Code are not allowable costs. 22

(C) "Ancillary and support costs" means all reasonable 23
costs incurred by a nursing facility other than direct care 24
costs, tax costs, or capital costs. "Ancillary and support 25
costs" includes, but is not limited to, costs of activities, 26
social services, pharmacy consultants, habilitation supervisors, 27
qualified intellectual disability professionals, program 28
directors, medical and habilitation records, program supplies, 29
incontinence supplies, food, enterals, dietary supplies and 30
personnel, laundry, housekeeping, security, administration, 31
medical equipment, utilities, liability insurance, bookkeeping, 32
purchasing department, human resources, communications, travel, 33
dues, license fees, subscriptions, home office costs not 34
otherwise allocated, legal services, accounting services, minor 35
equipment, maintenance and repairs, help-wanted advertising, 36
informational advertising, start-up costs, organizational 37
expenses, other interest, property insurance, employee training 38
and staff development, employee benefits, payroll taxes, and 39
workers' compensation premiums or costs for self-insurance 40
claims and related costs as specified in rules adopted under 41
section 5165.02 of the Revised Code, for personnel listed in 42
this division. "Ancillary and support costs" also means the cost 43
of equipment, including vehicles, acquired by operating lease 44
executed before December 1, 1992, if the costs are reported as 45
administrative and general costs on the nursing facility's cost 46
report for the cost reporting period ending December 31, 1992. 47

(D) "Applicable calendar year" means the calendar year 48
immediately preceding the calendar year that precedes the first 49
of the state fiscal years for which a rebasing is conducted. 50

(E) For purposes of calculating a critical access nursing 51
facility's occupancy rate and utilization rate under this 52
chapter, "as of the last day of the calendar year" refers to the 53
occupancy and utilization rates during the calendar year 54
identified in the cost report filed under section 5165.10 of the 55
Revised Code. 56

(F) (1) "Capital costs" means the actual expense incurred 57
by a nursing facility for all of the following: 58

(a) Depreciation and interest on any capital assets that 59
cost five hundred dollars or more per item, including the 60
following: 61

(i) Buildings; 62

(ii) Building improvements; 63

(iii) Except as provided in division (D) of this section, 64
equipment; 65

(iv) Transportation equipment. 66

(b) Amortization and interest on land improvements and 67
leasehold improvements; 68

(c) Amortization of financing costs; 69

(d) Lease and rent of land, buildings, and equipment. 70

(2) The costs of capital assets of less than five hundred 71
dollars per item may be considered capital costs in accordance 72
with a provider's practice. 73

(G) "Capital lease" and "operating lease" shall be 74

construed in accordance with generally accepted accounting principles.	75 76
(H) "Case-mix score" means a measure determined under section 5165.192 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a nursing facility resident.	77 78 79 80
(I) "Change of operator" means an entering operator becoming the operator of a nursing facility in the place of the exiting operator.	81 82 83
(1) Actions that constitute a change of operator include the following:	84 85
(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;	86 87 88
(b) A transfer of all the exiting operator's ownership interest in the operation of the nursing facility to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the nursing facility is also transferred;	89 90 91 92 93
(c) A lease of the nursing facility to the entering operator or the exiting operator's termination of the exiting operator's lease;	94 95 96
(d) If the exiting operator is a partnership, dissolution of the partnership;	97 98
(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:	99 100 101
(i) The change in composition does not cause the	102

partnership's dissolution under state law.	103
(ii) The partners agree that the change in composition	104
does not constitute a change in operator.	105
(f) If the operator is a corporation, dissolution of the	106
corporation, a merger of the corporation into another	107
corporation that is the survivor of the merger, or a	108
consolidation of one or more other corporations to form a new	109
corporation.	110
(2) The following, alone, do not constitute a change of	111
operator:	112
(a) A contract for an entity to manage a nursing facility	113
as the operator's agent, subject to the operator's approval of	114
daily operating and management decisions;	115
(b) A change of ownership, lease, or termination of a	116
lease of real property or personal property associated with a	117
nursing facility if an entering operator does not become the	118
operator in place of an exiting operator;	119
(c) If the operator is a corporation, a change of one or	120
more members of the corporation's governing body or transfer of	121
ownership of one or more shares of the corporation's stock, if	122
the same corporation continues to be the operator.	123
(J) "Cost center" means the following:	124
(1) Ancillary and support costs;	125
(2) Capital costs;	126
(3) Direct care costs;	127
(4) Tax costs.	128
(K) "Custom wheelchair" means a wheelchair to which both	129

of the following apply:	130
(1) It has been measured, fitted, or adapted in	131
consideration of either of the following:	132
(a) The body size or disability of the individual who is	133
to use the wheelchair;	134
(b) The individual's period of need for, or intended use	135
of, the wheelchair.	136
(2) It has customized features, modifications, or	137
components, such as adaptive seating and positioning systems,	138
that the supplier who assembled the wheelchair, or the	139
manufacturer from which the wheelchair was ordered, added or	140
made in accordance with the instructions of the physician of the	141
individual who is to use the wheelchair.	142
(L) (1) "Date of licensure" means the following:	143
(a) In the case of a nursing facility that was required by	144
law to be licensed as a nursing home under Chapter 3721. of the	145
Revised Code when it originally began to be operated as a	146
nursing home, the date the nursing facility was originally so	147
licensed;	148
(b) In the case of a nursing facility that was not	149
required by law to be licensed as a nursing home when it	150
originally began to be operated as a nursing home, the date it	151
first began to be operated as a nursing home, regardless of the	152
date the nursing facility was first licensed as a nursing home.	153
(2) If, after a nursing facility's original date of	154
licensure, more nursing home beds are added to the nursing	155
facility, the nursing facility has a different date of licensure	156
for the additional beds. This does not apply, however, to	157

additional beds when both of the following apply:	158
(a) The additional beds are located in a part of the nursing facility that was constructed at the same time as the continuing beds already located in that part of the nursing facility;	159 160 161 162
(b) The part of the nursing facility in which the additional beds are located was constructed as part of the nursing facility at a time when the nursing facility was not required by law to be licensed as a nursing home.	163 164 165 166
(3) The definition of "date of licensure" in this section applies in determinations of nursing facilities' medicaid payment rates but does not apply in determinations of nursing facilities' franchise permit fees.	167 168 169 170
(M) "Desk-reviewed" means that a nursing facility's costs as reported on a cost report submitted under section 5165.10 of the Revised Code have been subjected to a desk review under section 5165.108 of the Revised Code and preliminarily determined to be allowable costs.	171 172 173 174 175
(N) "Direct care costs" means all of the following costs incurred by a nursing facility:	176 177
(1) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the nursing facility;	178 179
(2) Costs for direct care staff, administrative nursing staff, medical directors, respiratory therapists, and except as provided in division (N)(8) of this section, other persons holding degrees qualifying them to provide therapy;	180 181 182 183
(3) Costs of purchased nursing services;	184
(4) Costs of quality assurance;	185

(5) Costs of training and staff development, employee	186
benefits, payroll taxes, and workers' compensation premiums or	187
costs for self-insurance claims and related costs as specified	188
in rules adopted under section 5165.02 of the Revised Code, for	189
personnel listed in divisions (N) (1), (2), (4), and (8) of this	190
section;	191
(6) Costs of consulting and management fees related to	192
direct care;	193
(7) Allocated direct care home office costs;	194
(8) Costs of habilitation staff (other than habilitation	195
supervisors), medical supplies, emergency oxygen, over-the-	196
counter pharmacy products, physical therapists, physical therapy	197
assistants, occupational therapists, occupational therapy	198
assistants, speech therapists, audiologists, habilitation	199
supplies, and universal precautions supplies;	200
(9) Costs of wheelchairs other than the following:	201
(a) Custom wheelchairs;	202
(b) Repairs to and replacements of custom wheelchairs and	203
parts that are made in accordance with the instructions of the	204
physician of the individual who uses the custom wheelchair.	205
(10) Costs of other direct-care resources that are	206
specified as direct care costs in rules adopted under section	207
5165.02 of the Revised Code.	208
(O) "Dual eligible individual" has the same meaning as in	209
section 5160.01 of the Revised Code.	210
(P) "Effective date of a change of operator" means the day	211
the entering operator becomes the operator of the nursing	212
facility.	213

(Q) "Effective date of a facility closure" means the last 214
day that the last of the residents of the nursing facility 215
resides in the nursing facility. 216

(R) "Effective date of an involuntary termination" means 217
the date the department of medicaid terminates the operator's 218
provider agreement for the nursing facility. 219

(S) "Effective date of a voluntary withdrawal of 220
participation" means the day the nursing facility ceases to 221
accept new medicaid residents other than the individuals who 222
reside in the nursing facility on the day before the effective 223
date of the voluntary withdrawal of participation. 224

(T) "Entering operator" means the person or government 225
entity that will become the operator of a nursing facility when 226
a change of operator occurs or following an involuntary 227
termination. 228

(U) "Exiting operator" means any of the following: 229

(1) An operator that will cease to be the operator of a 230
nursing facility on the effective date of a change of operator; 231

(2) An operator that will cease to be the operator of a 232
nursing facility on the effective date of a facility closure; 233

(3) An operator of a nursing facility that is undergoing 234
or has undergone a voluntary withdrawal of participation; 235

(4) An operator of a nursing facility that is undergoing 236
or has undergone an involuntary termination. 237

(V) (1) Subject to divisions (V) (2) and (3) of this 238
section, "facility closure" means either of the following: 239

(a) Discontinuance of the use of the building, or part of 240

the building, that houses the facility as a nursing facility 241
that results in the relocation of all of the nursing facility's 242
residents; 243

(b) Conversion of the building, or part of the building, 244
that houses a nursing facility to a different use with any 245
necessary license or other approval needed for that use being 246
obtained and one or more of the nursing facility's residents 247
remaining in the building, or part of the building, to receive 248
services under the new use. 249

(2) A facility closure occurs regardless of any of the 250
following: 251

(a) The operator completely or partially replacing the 252
nursing facility by constructing a new nursing facility or 253
transferring the nursing facility's license to another nursing 254
facility; 255

(b) The nursing facility's residents relocating to another 256
of the operator's nursing facilities; 257

(c) Any action the department of health takes regarding 258
the nursing facility's medicaid certification that may result in 259
the transfer of part of the nursing facility's survey findings 260
to another of the operator's nursing facilities; 261

(d) Any action the department of health takes regarding 262
the nursing facility's license under Chapter 3721. of the 263
Revised Code. 264

(3) A facility closure does not occur if all of the 265
nursing facility's residents are relocated due to an emergency 266
evacuation and one or more of the residents return to a 267
medicaid-certified bed in the nursing facility not later than 268
thirty days after the evacuation occurs. 269

(W) "Franchise permit fee" means the fee imposed by	270
sections 5168.40 to 5168.56 of the Revised Code.	271
(X) "Inpatient days" means both of the following:	272
(1) All days during which a resident, regardless of	273
payment source, occupies a licensed bed in a nursing facility;	274
(2) Fifty per cent of the days for which payment is made	275
under section 5165.34 of the Revised Code.	276
(Y) "Involuntary termination" means the department of	277
medicaid's termination of the operator's provider agreement for	278
the nursing facility when the termination is not taken at the	279
operator's request.	280
(Z) "Low resource utilization resident" means a medicaid	281
recipient residing in a nursing facility who, for purposes of	282
calculating the nursing facility's medicaid payment rate for	283
direct care costs, is placed in either of the two lowest	284
resource utilization groups, excluding any resource utilization	285
group that is a default group used for residents with incomplete	286
assessment data.	287
(AA) "Maintenance and repair expenses" means a nursing	288
facility's expenditures that are necessary and proper to	289
maintain an asset in a normally efficient working condition and	290
that do not extend the useful life of the asset two years or	291
more. "Maintenance and repair expenses" includes but is not	292
limited to the costs of ordinary repairs such as painting and	293
wallpapering.	294
(BB) "Medicaid-certified capacity" means the number of a	295
nursing facility's beds that are certified for participation in	296
medicaid as nursing facility beds.	297

(CC) "Medicaid days" means both of the following:	298
(1) All days during which a resident who is a medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's medicaid-certified capacity;	299 300 301 302
(2) Fifty per cent of the days for which payment is made under section 5165.34 of the Revised Code.	303 304
(DD) (1) "New nursing facility" means a nursing facility for which the provider obtains an initial provider agreement following medicaid certification of the nursing facility by the director of health, including such a nursing facility that replaces one or more nursing facilities for which a provider previously held a provider agreement.	305 306 307 308 309 310
(2) "New nursing facility" does not mean a nursing facility for which the entering operator seeks a provider agreement pursuant to section 5165.511 or 5165.512 or (pursuant to section 5165.515) section 5165.07 of the Revised Code.	311 312 313 314
(EE) "Nursing facility" has the same meaning as in the "Social Security Act," section 1919(a), 42 U.S.C. 1396r(a).	315 316
(FF) "Nursing facility services" has the same meaning as in the "Social Security Act," section 1905(f), 42 U.S.C. 1396d(f).	317 318 319
(GG) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.	320 321
(HH) "Occupancy rate" means the percentage of licensed beds that, regardless of payer source, are either of the following:	322 323 324
(1) Reserved for use under section 5165.34 of the Revised	325

Code;	326
(2) Actually being used.	327
(II) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing facility.	328 329 330
(JJ) (1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility:	331 332 333 334
(a) The land on which the nursing facility is located;	335
(b) The structure in which the nursing facility is located;	336 337
(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the nursing facility is located;	338 339 340
(d) Any lease or sublease of the land or structure on or in which the nursing facility is located.	341 342
(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility and purchased at public issue or a regulated lender that has made a loan related to the nursing facility unless the holder or lender operates the nursing facility directly or through a subsidiary.	343 344 345 346 347
(KK) "Per diem" means a nursing facility's actual, allowable costs in a given cost center in a cost reporting period, divided by the nursing facility's inpatient days for that cost reporting period.	348 349 350 351
(LL) <u>"Private room" means a room with permanent walls that</u>	352

contains one licensed or certified bed that is occupied by one 353
individual, with direct unshared access to a hallway, and direct 354
unshared access to a toilet and sink shared by not more than one 355
other private room, and that meets all applicable licensure or 356
other standards pertaining to furniture, fixtures, and 357
temperature control. 358

(MM) "Private room capacity" means the total number of 359
private rooms in a nursing facility, as calculated and adjusted 360
according to section 5165.27 of the Revised Code. 361

(NN) "Provider" means an operator with a provider 362
agreement. 363

~~(MM)~~ (OO) "Provider agreement" means a provider agreement, 364
as defined in section 5164.01 of the Revised Code, that is 365
between the department of medicaid and the operator of a nursing 366
facility for the provision of nursing facility services under 367
the medicaid program. 368

~~(NN)~~ (PP) "Purchased nursing services" means services that 369
are provided in a nursing facility by registered nurses, 370
licensed practical nurses, or nurse aides who are not employees 371
of the nursing facility. 372

~~(OO)~~ (QQ) "Reasonable" means that a cost is an actual cost 373
that is appropriate and helpful to develop and maintain the 374
operation of patient care facilities and activities, including 375
normal standby costs, and that does not exceed what a prudent 376
buyer pays for a given item or services. Reasonable costs may 377
vary from provider to provider and from time to time for the 378
same provider. 379

~~(PP)~~ (RR) "Rebasing" means a redetermination of each of 380
the following using information from cost reports for an 381

applicable calendar year that is later than the applicable	382
calendar year used for the previous rebasing:	383
(1) Each peer group's rate for ancillary and support costs	384
as determined pursuant to division (C) of section 5165.16 of the	385
Revised Code;	386
(2) Each peer group's rate for capital costs as determined	387
pursuant to division (C) of section 5165.17 of the Revised Code;	388
(3) Each peer group's cost per case-mix unit as determined	389
pursuant to division (C) of section 5165.19 of the Revised Code;	390
(4) Each nursing facility's rate for tax costs as	391
determined pursuant to section 5165.21 of the Revised Code.	392
(QQ) <u>(SS)</u> "Related party" means an individual or	393
organization that, to a significant extent, has common ownership	394
with, is associated or affiliated with, has control of, or is	395
controlled by, the provider.	396
(1) An individual who is a relative of an owner is a	397
related party.	398
(2) Common ownership exists when an individual or	399
individuals possess significant ownership or equity in both the	400
provider and the other organization. Significant ownership or	401
equity exists when an individual or individuals possess five per	402
cent ownership or equity in both the provider and a supplier.	403
Significant ownership or equity is presumed to exist when an	404
individual or individuals possess ten per cent ownership or	405
equity in both the provider and another organization from which	406
the provider purchases or leases real property.	407
(3) Control exists when an individual or organization has	408
the power, directly or indirectly, to significantly influence or	409

direct the actions or policies of an organization.	410
(4) An individual or organization that supplies goods or	411
services to a provider shall not be considered a related party	412
if all of the following conditions are met:	413
(a) The supplier is a separate bona fide organization.	414
(b) A substantial part of the supplier's business activity	415
of the type carried on with the provider is transacted with	416
others than the provider and there is an open, competitive	417
market for the types of goods or services the supplier	418
furnishes.	419
(c) The types of goods or services are commonly obtained	420
by other nursing facilities from outside organizations and are	421
not a basic element of patient care ordinarily furnished	422
directly to patients by nursing facilities.	423
(d) The charge to the provider is in line with the charge	424
for the goods or services in the open market and no more than	425
the charge made under comparable circumstances to others by the	426
supplier.	427
(RR) <u>(TT)</u> "Relative of owner" means an individual who is	428
related to an owner of a nursing facility by one of the	429
following relationships:	430
(1) Spouse;	431
(2) Natural parent, child, or sibling;	432
(3) Adopted parent, child, or sibling;	433
(4) Stepparent, stepchild, stepbrother, or stepsister;	434
(5) Father-in-law, mother-in-law, son-in-law, daughter-in-	435
law, brother-in-law, or sister-in-law;	436

(6) Grandparent or grandchild;	437
(7) Foster caregiver, foster child, foster brother, or foster sister.	438 439
(SS) <u>(UU)</u> "Residents' rights advocate" has the same meaning as in section 3721.10 of the Revised Code.	440 441
(TT) <u>(VV)</u> "Skilled nursing facility" has the same meaning as in the "Social Security Act," section 1819(a), 42 U.S.C. 1395i-3(a).	442 443 444
(UU) <u>(WW)</u> "State fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.	445 446
(VV) <u>(XX)</u> "Sponsor" has the same meaning as in section 3721.10 of the Revised Code.	447 448
(WW) <u>(YY)</u> "Tax costs" means the costs of taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes.	449 450 451
(XX) <u>(ZZ)</u> "Title XIX" means Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq.	452 453
(YY) <u>(AAA)</u> "Title XVIII" means Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.	454 455
(ZZ) <u>(BBB)</u> "Voluntary withdrawal of participation" means an operator's voluntary election to terminate the participation of a nursing facility in the medicaid program but to continue to provide service of the type provided by a nursing facility.	456 457 458 459
Sec. 5165.15. Except as otherwise provided by sections 5165.151 to 5165.157 and 5165.34 of the Revised Code, the total per medicaid day payment rate that the department of medicaid shall pay a nursing facility provider for nursing facility	460 461 462 463

services the provider's nursing facility provides during a state	464
fiscal year shall be determined as follows:	465
(A) Determine the sum of all of the following:	466
(1) The per medicaid day payment rate for ancillary and	467
support costs determined for the nursing facility under section	468
5165.16 of the Revised Code;	469
(2) The per medicaid day payment rate for capital costs	470
determined for the nursing facility under section 5165.17 of the	471
Revised Code;	472
(3) The per medicaid day payment rate for direct care	473
costs determined for the nursing facility under section 5165.19	474
of the Revised Code;	475
(4) The per medicaid day payment rate for tax costs	476
determined for the nursing facility under section 5165.21 of the	477
Revised Code;	478
(5) If the nursing facility qualifies as a critical access	479
nursing facility, the nursing facility's critical access	480
incentive payment paid under section 5165.23 of the Revised	481
Code;	482
<u>(6) If the nursing facility is providing services to a</u>	483
<u>medicaid recipient in a private room, the private room per day</u>	484
<u>rate determined under section 5165.27 of the Revised Code.</u>	485
(B) To the sum determined under division (A) of this	486
section, add sixteen dollars and forty-four cents.	487
(C) From the sum determined under division (B) of this	488
section, subtract one dollar and seventy-nine cents.	489
(D) To the sum determined under division (C) of this	490

section, add, for state fiscal year 2022 and for state fiscal 491
year 2023, the per medicaid day quality incentive payment rate 492
determined for the nursing facility under section 5165.26 of the 493
Revised Code. 494

Sec. 5165.27. (A) In accordance with this section and 495
section 5165.15 of the Revised Code, the department of medicaid 496
shall pay a private room per day rate to each nursing facility 497
provider that provides, or has provided, services to a medicaid 498
recipient in a private room on or after July 1, 2022. 499

(B) A nursing facility's private room per day rate for 500
state fiscal year 2023 is twenty-five dollars. The department 501
shall determine the private room per day rate for subsequent 502
fiscal years. 503

(C) For purposes of this section, a nursing facility's 504
private room capacity means the total number of private rooms in 505
the facility, calculated pursuant to this division. After the 506
initial calculation, a facility's private room capacity may 507
change only if the facility removes licensed beds from their 508
licensed capacity or, if the facility does not hold a license, 509
the facility surrenders beds that have been certified by the 510
U.S. centers for medicare and medicaid services. A nursing 511
facility's private room capacity for a fiscal year shall be 512
calculated as follows: 513

(1) Determine the number of resident rooms in the nursing 514
facility that are occupied or that are available to be occupied 515
by a resident during the fiscal year; 516

(2) Determine the number of licensed beds for that nursing 517
facility during the fiscal year, or, if the facility is not 518
licensed, the number of certified beds; 519

(3) Subtract the sum determined under division (C) (1) of 520
this section from the sum determined under division (C) (2) of 521
this section; 522

(4) Subtract the sum determined under division (C) (3) of 523
this section from the sum determined under division (C) (1) of 524
this section. 525

(D) A nursing facility provider shall not bill the 526
department for more private rooms in one day than the facility's 527
private room capacity. The department may recoup the excess 528
amount paid to a nursing facility provider for any private room 529
days billed that exceed the facility's private room capacity and 530
may use vendor offsets to recoup the payments. 531

(E) Not later than sixty days after the effective date of 532
this section, the department shall calculate the initial private 533
room capacity for each nursing facility in this state. In the 534
case of a new nursing facility, the department shall calculate 535
the facility's initial private room capacity not later than 536
sixty days after the date the facility is certified as a nursing 537
facility by the U.S. centers for medicare and medicaid services. 538
Each nursing facility provider shall submit, and the department 539
shall collect, the number of rooms occupied and available for 540
occupancy, in the manner prescribed by the department. 541

(1) If a nursing facility provider removes medicaid beds 542
licensed by the department of health or surrenders beds that 543
were certified by the U.S. centers for medicare and medicaid 544
services, the provider shall notify the department of medicaid 545
of the number of beds removed or surrendered and the effective 546
date of the change. Upon receiving such a notice, the department 547
of medicaid shall do all of the following: 548

<u>(a) Verify the number of beds removed and the effective</u>	549
<u>date of the removal with the department of health, if</u>	550
<u>applicable;</u>	551
<u>(b) Not later than sixty days after receipt of the</u>	552
<u>notification, adjust the facility's private room capacity in</u>	553
<u>accordance with division (C) of this section;</u>	554
<u>(c) Amend the facility's provider agreement.</u>	555
<u>(2) The department of medicaid shall include in a</u>	556
<u>facility's private room per day rate the adjusted private room</u>	557
<u>capacity for the facility calculated pursuant to division (E) (1)</u>	558
<u>of this section beginning on the later of the following:</u>	559
<u>(a) The date the beds were removed or surrendered;</u>	560
<u>(b) The date the department received the notice of the</u>	561
<u>removal or surrender under division (E) (1) of this section.</u>	562
Section 2. That existing sections 5165.01 and 5165.15 of	563
the Revised Code are hereby repealed.	564