WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1996

ENROLLED

HOUSE BILL No. 4137

(By Delegates Compton, Powe, Peterson, Leach, Burke, Hutchins and Wallace)

Passed March 9, 1996

In Effect From Passage

ENROLLED

H. B. 4137

(By Delegates Compton, Rowe, Petersen, Leach, Burke, Hutchins and Wallace)

[Passed March 9, 1996; in effect from passage.]

AN ACT to amend and reenact sections two, three and five, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact section two, article five-f of said chapter, relating to certificate of need standards generally; clarifying certificate of need standards for hospice agencies and home health facilities; allowing conversion of certain beds at hospitals; and allowing rate and regulatory relief to be granted by the state agency.

Be it enacted by the Legislature of West Virginia:

That sections two, three and five, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and to amend and reenact section two, article five-f of said chapter, all to read as follows:

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-2. Definitions.

As used in this article, unless otherwise indicated by the context:

(a) "Affected person" means:

(1) The applicant;

(2) An agency or organization representing consumers;

(3) Any individual residing within the geographic area served or to be served by the applicant;

(4) Any individual who regularly uses the health care facilities within that geographic area;

(5) The health care facilities which provide services similar to the services of the facility under review and which will be significantly affected by the proposed project;

(6) The health care facilities which, prior to receipt by the state agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future;

(7) Third-party payors who reimburse health care facilities similar to those proposed for services;

(8) Any agency which establishes rates for health care facilities similar to those proposed; or

(9) Organizations representing health care providers.

(b) "Ambulatory health care facility" means a facility which is free-standing and not physically attached to a health care facility and which provides health care to noninstitutionalized and nonhomebound persons on an outpatient basis. This definition does not include the private office practice of any one or more health professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code: *Provided,* That such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: *Provided, however,* That such exemption from review of private office practice shall not be construed to include certain health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(c) "Ambulatory surgical facility" means a facility which is free-standing and not physically attached to a health care facility and which provides surgical treatment

to patients not requiring hospitalization. This definition does not include the private office practice of any one or more health professionals licensed to practice surgery in this state pursuant to the provisions of chapter thirty of this code: *Provided,* That such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: *Provided, however,* That such exemption from review of private office practice shall not be construed to include certain health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(d) "Applicant" means: (1) The governing body or the person proposing a new institutional health service who is, or will be, the health care facility licensee wherein the new institutional health service is proposed to be located, and (2) in the case of a proposed new institutional health service not to be located in a licensed health care facility, the governing body or the person proposing to provide such new institutional health service. Incorporators or promoters who will not constitute the governing body or persons responsible for the new institutional health service may not be an applicant.

(e) "Bed capacity" means the number of beds for which a license is issued to a health care facility, or, if a facility is unlicensed, the number of adult and pediatric beds permanently staffed and maintained for immediate use by inpatients in patient rooms or wards.

(f) "Capital expenditure" means an expenditure:

(1) Made by or on behalf of a health care facility; and

(2) (A) Which (i) under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or (ii) is made to obtain either by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and (B) which (i) exceeds the expenditure minimum, or (ii) is a substantial change to the bed capacity of the facility with respect to which the expenditure is made, or (iii) is a sub-

stantial change to the services of such facility. For purposes of subparagraph (i), paragraph (B), subdivision (2) of this definition, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure described in paragraph (B), subdivision (2) of this definition is made shall be included in determining if such expenditure exceeds the expenditure minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of such subdivisions if a transfer of the equipment or facilities at fair market value would be subject to review. A series of expenditures, each less than the expenditure minimum, which when taken together are in excess of the expenditure minimum, may be determined by the state agency to be a single capital expenditure subject to review. In making its determination, the state agency shall consider: Whether the expenditures are for components of a system which is required to accomplish a single purpose; whether the expenditures are to be made over a two-year period and are directed towards the accomplishment of a single goal within the health care facility's long-range plan; or whether the expenditures are to be made within a two-year period within a single department such that they will constitute a significant modernization of the department.

(g) "Expenditure minimum" means seven hundred fifty thousand dollars per fiscal year.

(h) "Health," used as a term, includes physical and mental health.

(i) "Health care facility" is defined as including hospitals, skilled nursing facilities, kidney disease treatment centers, including free-standing hemodialysis units, intermediate care facilities, ambulatory health care facilities, ambulatory surgical facilities, home health agencies, hos-

pice agencies, rehabilitation facilities and health maintenance organizations; community mental health and mental retardation facilities, whether under public or private ownership, or as a profit or nonprofit organization and whether or not licensed or required to be licensed in whole or in part by the state. For purposes of this definition, "community mental health and mental retardation facility" means a private facility which provides such comprehensive services and continuity of care as emergency, outpatient, partial hospitalization, inpatient and consultation and education for individuals with mental illness, mental retardation or drug or alcohol addiction.

(j) "Health care provider" means a person, partnership, corporation, facility or institution licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement.

(k) "Health maintenance organization" means a public or private organization, organized under the laws of this state, which:

(1) Is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act, as amended, Title 42 United States Code Section 300e-9(d); or

(2) (A) Provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: Usual physician services, hospitalization, laboratory, X ray, emergency and preventive services and out-of-area coverage; and

(B) Is compensated except for copayments for the provision of the basic health care services listed in paragraph (A), subdivision (2), subsection (k) of this definition to enrolled participants on a predetermined periodic rate basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent or kind of health service actually provided; and

(C) Provides physicians' services primarily (i) directly through physicians who are either employees or partners

of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(l) "Health services" means clinically related preventive, diagnostic, treatment or rehabilitative services, including alcohol, drug abuse and mental health services.

(m) "Home health agency" is an organization primarily engaged in providing professional nursing services either directly or through contract arrangements and at least one of the following services: Home health aide services, other therapeutic services, physical therapy, speech therapy, occupational therapy, nutritional services or medical social services to persons in their place of residence on a part-time or intermittent basis.

(n) "Hospice agency" means a private or public agency or organization licensed in West Virginia for the administration or provision of hospice care services to terminally ill persons in such persons' temporary or permanent residences by using an interdisciplinary team, including, at a minimum, persons qualified to perform nursing, social work services, the general practice of medicine or osteopathy and pastoral or spiritual counseling.

(o) "Hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. This term also includes psychiatric and tuberculosis hospitals.

(p) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services above the level of room and board.

(q) "Long-range plan" means a document formally adopted by the legally constituted governing body of an

existing health care facility or by a person proposing a new institutional health service. Each long-range plan shall consist of the information required by the state agency in regulations adopted pursuant to section eight of this article.

(r) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used for the provision of medical and other health services and which costs in excess of three hundred thousand dollars, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs ten and eleven of Section 1861(s) of such act, Title 42 United States Code Sections 1395x (10) and (11). In determining whether medical equipment costs more than three hundred thousand dollars, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

(s) "Medically underserved population" means the population of an urban or rural area designated by the state agency as an area with a shortage of personal health services or a population having a shortage of such services, after taking into account unusual local conditions which are a barrier to accessibility or availability of such services. Such designation shall be in regulations adopted by the state agency pursuant to section eight of this article, and the population so designated may include the state's medically underserved population designated by the Federal Secretary of Health and Human Services under Section 330(b)(3) of the Public Health Service Act, as amended, Title 42 United States Code Section 254(b)(3).

(t) "New institutional health service" means such service as described in section three of this article.

(u) "Offer", when used in connection with health services, means that the health care facility or health maintenance organization holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(v) "Person" means an individual, trust, estate, partnership, committee, corporation, association and other organizations such as joint-stock companies and insurance companies, a state or a political subdivision or instrumentality thereof or any legal entity recognized by the state.

(w) "Physician" means a doctor of medicine or osteopathy legally authorized to practice by the state.

(x) "Proposed new institutional health service" means such service as described in section three of this article.

(y) "Psychiatric hospital" means an institution which primarily provides to inpatients, by or under the supervision of a physician, specialized services for the diagnosis, treatment and rehabilitation of mentally ill and emotionally disturbed persons.

(z) "Rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

(aa) "Review agency" means an agency of the state, designated by the governor as the agency for the review of state agency decisions.

(bb) "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(cc) "State agency" means the health care cost review authority created, established, and continued pursuant to article twenty-nine-b of this chapter.

(dd) "State health plan" means the document ap-

proved by the governor after preparation by the former statewide health coordinating council, or that document as approved by the governor after amendment by the health care planning council or its successor agency.

(ee) "Health care planning council" means the body established by section five-a of this article to participate in the preparation and amendment of the state health plan and to advise the state agency.

(ff) "Substantial change to the bed capacity" of a health care facility means any change, with which a capital expenditure is associated, that increases or decreases the bed capacity, or relocates beds from one physical facility or site to another, but does not include a change by which a health care facility reassigns existing beds as swing beds between acute care and long-term care categories: *Provided,* That a decrease in bed capacity in response to federal rural health initiatives shall be excluded from this definition.

(gg) "Substantial change to the health services" of a health care facility means the addition of a health service which is offered by or on behalf of the health care facility and which was not offered by or on behalf of the facility within the twelve-month period before the month in which the service is first offered, or the termination of a health service which was offered by or on behalf of the facility: *Provided,* That "substantial change to the health services" does not include the providing of ambulance service, wellness centers or programs, adult day care, or respite care by acute care facilities.

(hh) "To develop", when used in connection with health services, means to undertake those activities which upon their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, in relation to the offering of such a service.

§16-2D-3. Certificate of need; new institutional health services defined.

(a) Except as provided in section four of this article, any new institutional health service may not be acquired, offered or developed within this state except upon applica-

tion for and receipt of a certificate of need as provided by this article. Whenever a new institutional health service for which a certificate of need is required by this article is proposed for a health care facility for which, pursuant to section four of this article, no certificate of need is or was required, a certificate of need shall be issued before the new institutional health service is offered or developed. No person may knowingly charge or bill for any health services associated with any new institutional health service that is knowingly acquired, offered or developed in violation of this article, and any bill made in violation of this section is legally unenforceable.

(b) For purposes of this article, a proposed "new institutional health service" includes:

(1) The construction, development, acquisition or other establishment of a new health care facility or health maintenance organization;

(2) The partial or total closure of a health care facility or health maintenance organization with which a capital expenditure is associated;

(3) Any obligation for a capital expenditure incurred by or on behalf of a health care facility, except as exempted in section four of this article, or health maintenance organization in excess of the expenditure minimum or any obligation for a capital expenditure incurred by any person to acquire a health care facility. An obligation for a capital expenditure is considered to be incurred by or on behalf of a health care facility;

(A) When a contract, enforceable under state law, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset;

(B) When the governing board of the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or

(C) In the case of donated property, on the date on which the gift is completed under state law;

(4) A substantial change to the bed capacity of a health care facility with which a capital expenditure is associated;

(5) The addition of health services which are offered by or on behalf of a health care facility or health maintenance organization and which were not offered on a regular basis by or on behalf of the health care facility or health maintenance organization within the twelve-month period prior to the time the services would be offered;

(6) The addition of ventilator services for any nursing facility bed by any health care facility or health maintenance organization;

(7) The deletion of one or more health services, previously offered on a regular basis by or on behalf of a health care facility or health maintenance organization which is associated with a capital expenditure;

(8) A substantial change to the bed capacity or health services offered by or on behalf of a health care facility, whether or not the change is associated with a proposed capital expenditure, if the change is associated with a previous capital expenditure for which a certificate of need was issued and if the change will occur within two years after the date the activity which was associated with the previously approved capital expenditure was undertaken;

(9) The acquisition of major medical equipment;

(10) A substantial change in an approved new institutional health service for which a certificate of need is in effect. For purposes of this subsection, "substantial change" shall be defined by the state agency in regulations adopted pursuant to section eight of this article; or

(11) An expansion of the service area for hospice or home health service, regardless of the time period in which the expansion is contemplated or made.

§16-2D-5. Powers and duties of state agency.

(a) The state agency is hereby empowered to administer the certificate of need program as provided by this article.

(b) The state agency shall be responsible for coordinating and developing the health planning research efforts of the state and for amending and modifying the state health plan which includes the certificate of need standards.

(c) The state agency may seek advice and assistance of other persons, organizations and other state agencies in the performance of the state agency's responsibilities under this article.

(d) For health services for which competition appropriately allocates supply consistent with the state health plan, the state agency shall, in the performance of its functions under this article, give priority, where appropriate to advance the purposes of quality assurance, cost effectiveness and access, to actions which would strengthen the effect of competition on the supply of such services.

(e) For health services for which competition does not or will not appropriately allocate supply consistent with the state health plan, the state agency shall, in the exercise of its functions under this article, take actions, where appropriate to advance the purposes of quality assurance, cost effectiveness and access and the other purposes of this article, to allocate the supply of such services.

(f) Notwithstanding the provisions of section seven of this article, the state agency may charge a fee for the filing of any application, the filing of any notice in lieu of an application, the filing of any exemption determination request or the filing of any request for a declaratory ruling. The fees charged may vary according to the type of matter involved, the type of health service or facility involved or the amount of capital expenditure involved. The state agency shall implement this subsection by filing procedural rules pursuant to chapter twenty-nine-a of this code. The fees charged shall be deposited into a special fund known as the certificate of need program fund to be expended for the purposes of this article.

(g) No hospital, nursing home or other health care facility shall add any intermediate care or skilled nursing beds to its current licensed bed complement. This prohibi-

tion also applies to the conversion of acute care or other types of beds to intermediate care or skilled nursing beds: *Provided,* That hospitals eligible under the provisions of section four-a and subsection (i), section five of this article may convert acute care beds to skilled nursing beds in accordance with the provisions of these sections, upon approval by the state agency. Furthermore, no certificate of need shall be granted for the construction or addition of any intermediate care or skilled nursing beds except in the case of facilities designed to replace existing beds in unsafe existing facilities. A health care facility in receipt of a certificate of need for the construction or addition of intermediate care or skilled nursing beds which was approved prior to the effective date of this section must incur an obligation for a capital expenditure within twelve months of the date of issuance of the certificate of need. No extensions shall be granted beyond the twelve-month period: *Provided, however,* That a maximum of sixty beds may be approved, as a demonstration project, by the state agency for a unit to provide nursing services to patients with alzheimer's disease if: (1) The unit is located in an existing facility which was formerly owned and operated by the state of West Virginia and is presently owned by a county of the state of West Virginia; (2) the facility has provided health care services, including personal care services, within one year prior to the effective date of this section; (3) the facility demonstrates that awarding the certificate of need and operating the facility will be cost effective for the state; and (4) that any applicable lease, lease-purchase or contract for operating the facility was awarded through a process of competitive bidding consistent with state purchasing practices and procedures: *Provided further,* That an application for said demonstration project shall be filed with the state agency on or before the twenty-first day of October, one thousand nine hundred ninety-three.

(h) No additional intermediate care facility for the mentally retarded (ICF/MR) beds shall be granted a certificate of need, except that prohibition does not apply to ICF/MR beds approved under the Kanawha County circuit court order of the third day of August, one thousand nine

hundred eighty-nine, civil action number MISC-81-585 issued in the case of *E. H. v. Matin*, 168 W.V. 248, 284 S.E.2d 232 (1981).

(i) Notwithstanding the provisions of subsection (g), section five of this article and, further notwithstanding the provisions of subsection (d), section three of this article, an existing acute care hospital may apply to the health care cost review authority for a certificate of need to convert acute care beds to skilled nursing beds: *Provided,* That the proposed skilled nursing beds are medicare certified only: *Provided, however,* That any hospital which converts acute care beds to medicare certified only skilled nursing beds is prohibited from billing for any medicaid reimbursement for any beds so converted. In converting beds, the hospital must convert a minimum of one acute care bed into one medicare certified only skilled nursing bed. The health care cost review authority may require a hospital to convert up to and including three acute care beds for each medicare certified only skilled nursing bed: *Provided,* That a hospital designated or provisionally designated by the state agency as a rural primary care hospital may convert up to thirty beds to a distinct-part nursing facility, including skilled nursing beds and intermediate care beds, on a one-for-one basis if said rural primary care hospital is located in a county without a certified free-standing nursing facility and the hospital may bill for medicaid reimbursement for the converted beds: *Provided, however,* that if the hospital rejects the designation as a rural primary care hospital then the hospital may not bill for medicaid reimbursement. The health care cost review authority shall adopt rules to implement this subsection which require that:

(1) All acute care beds converted shall be permanently deleted from the hospital's acute care bed complement and the hospital may not thereafter add, by conversion or otherwise, acute care beds to its bed complement without satisfying the requirements of subsection (d), section three of this article for which purposes such an addition, whether by conversion or otherwise, shall be considered a substantial change to the bed capacity of the hospital notwithstanding the definition of that term found in subsection

(ee), section two of this article.

(2) The hospital shall meet all federal and state licensing certification and operational requirements applicable to nursing homes including a requirement that all skilled care beds created under this subsection shall be located in distinct-part, long-term care units.

(3) The hospital must demonstrate a need for the project.

(4) The hospital must use existing space for the medicare certified only skilled nursing beds. Under no circumstances shall the hospital construct, lease or acquire additional space for purposes of this section.

(5) The hospital must notify the acute care patient, prior to discharge, of facilities with skilled nursing beds which are located in or near the patient's county of residence.

Nothing in this subsection shall negatively affect the rights of inspection and certification which are otherwise required by federal law or regulations or by this code of duly adopted regulations of an authorized state entity.

(j) Notwithstanding the provisions of subsection (g) of this section, a retirement life care center with no skilled nursing beds may apply to the health care cost review authority for a certificate of need for up to sixty skilled nursing beds provided the proposed skilled beds are medicare certified only. On a statewide basis, a maximum of one hundred eighty skilled beds which are medicare certified only may be developed pursuant to this subsection. The state health plan shall not be applicable to projects submitted under this subsection. The health care cost review authority shall adopt rules to implement this subsection which shall include:

(1) A requirement that the one hundred eighty beds are to be distributed on a statewide basis;

(2) There shall be a minimum of twenty beds and a maximum of sixty beds in each approved unit;

(3) The unit developed by the retirement life care

center shall meet all federal and state licensing certification and operational requirements applicable to nursing homes;

(4) The retirement center must demonstrate a need for the project;

(5) The retirement center must offer personal care, home health services and other lower levels of care to its residents; and

(6) The retirement center must demonstrate both short and long-term financial feasibility.

Nothing in this subsection shall negatively affect the rights of inspection and certification which are otherwise required by federal law or regulations or by this code of duly adopted regulations of an authorized state entity.

(k) The provisions of this article are severable and if any provision, section or part thereby shall be held invalid, unconstitutional or inapplicable to any person or circumstance, such invalidity, unconstitutionality or inapplicability shall not affect or impair any other remaining provisions contained herein.

(l) The state agency is hereby empowered to order a moratorium upon the processing of an application or applications for the development of a new institutional health service filed pursuant to section three of this article, when criteria and guidelines for evaluating the need for such new institutional health service have not yet been adopted or are obsolete. Such moratorium shall be declared by a written order which shall detail the circumstances requiring the moratorium. Upon the adoption of criteria for evaluating the need for the new institutional health service affected by the moratorium, or one hundred eighty days from the declaration of a moratorium, whichever is less, the moratorium shall be declared to be over and affected applications shall be processed pursuant to section six of this article.

(m) The state agency shall coordinate the collection of information needed to allow the state agency to develop

recommended modifications to certificate of need standards as required in this article. When the state agency proposes amendments or modifications to the certificate of need standards, they shall file with the secretary of state, for publication in the state register, a notice of proposed action, including the text of all proposed amendments and modifications, and a date, time and place for receipt of general public comment. To comply with the public comment requirement of this section, the state agency may hold a public hearing or schedule a public comment period for the receipt of written statements or documents.

All proposed amendments and modifications to the certificate of need standards, with a record of the public hearing or written statements and documents received pursuant to a public comment period, shall be presented to the governor. Within thirty days of receiving said proposed amendments or modifications, the governor shall either approve or disapprove all or part of said amendments and modifications, and, for any portion of amendments or modifications not approved, shall specify the reason or reasons for nonapproval. Any portions of the amendments or modifications not approved by the governor may be revised and resubmitted.

(n) The state agency may exempt from or expedite rate review, certificate of need, and annual assessment requirements and issue grants and loans to financially vulnerable health care facilities located in underserved areas that the state agency and the office of community and rural health services determine are collaborating with other providers in the service area to provide cost effective health care services.

ARTICLE 5F. HEALTH CARE FINANCIAL DISCLOSURE.

§16-5F-2. Definitions.

As used in this article:

(1) "Annual report" means an annual financial report for the covered facility's or related organization's fiscal year prepared by an accountant or the covered facility's or related organization's auditor.

(2) "Board" means the West Virginia health care cost review authority.

(3) "Covered facility" means any hospital, skilled nursing facility, kidney disease treatment center, including a free-standing hemodialysis unit; intermediate care facility; ambulatory health care facility; ambulatory surgical facility; home health agency; hospice agency; rehabilitation facility; health maintenance organization; or community mental health or mental retardation facility, whether under public or private ownership or as a profit or nonprofit organization and whether or not licensed or required to be licensed in whole or in part by the state: *Provided,* That nonprofit, community-based primary care centers providing primary care services without regard to ability to pay who provide the board with a year-end audited financial statement prepared in accordance with generally accepted auditing standards and with governmental auditing standards issued by the comptroller general of the United States shall be deemed to have complied with the disclosure requirements of this section.

(4) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a covered facility through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners, including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For the purposes of this subdivision "family members" shall mean brothers and sisters whether by the whole or half blood, spouse, ancestors and lineal descendants.

(5) "Rates" means all rates, fees or charges imposed by any covered facility for health care services.

(6) "Records" includes accounts, books, charts, contracts, documents, files, maps, papers, profiles, reports, annual and otherwise, schedules and any other fiscal data, however recorded or stored.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within ~~is~~ approved this the 19th day of March, 1996.

Governor

PRESENTED TO THE

GOVERNOR

Date 3/19/96

Time 3:25 pm