Chapter HSS 122

LONG-TERM CARE FACILITY BED ADDITIONS AND CAPITAL EXPENDITURES REVIEW

Note: Chapter HSS 122 was created as an emergency rule effective January 1, 1984. This chapter and chapter HSS 123 replace chapter H 3.

HSS 122.01 Authority and purpose. This chapter is promulgated under the authority of s. 150.03, Stats. It provides definitions, criteria and procedures to implement subchs. I and II of ch. 150, Stats., concerning containment of health care costs through the biennial establishment of a limit on the number of nursing home beds permitted in the state, interim adjustments to that limit and approval by the department of projects proposing to add to the supply of nursing home beds and of other projects proposing capital expenditures for nursing homes in excess of $600,000.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.02 Applicability. This chapter applies to all activities described in s. 150.21, Stats., undertaken by or on behalf of any nursing home including any facility for the developmentally disabled (FDD).

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.03 Definitions. In this chapter:

(1) "Affected party" means:

(a) The applicant;

(b) Other persons providing similar services in the applicant's planning area;

(c) Members of the public to be served by the project;

(d) The HSA in the area in which the nursing home project under review is or will be located, and other planning agencies, including area agencies on aging and zoning authorities;

(e) Other applicants undergoing concurrent review;

(f) Local units of government, including county boards of supervisors and city councils, and the administrative agencies serving those units of government; and

(g) Third-party payers.

(2) "Applicant" means a person who requests an approval or for whom an approval is requested.

(3) "Approval" means a written statement from the department authorizing a person to commence implementation of a reviewed project.

(4) "Approval holder" means a person to whom an approval has been issued.

(5) "Biennium" means a two-year period beginning on July 1 of an odd-numbered year.

(6) "Capital expenditure" means an expenditure by or on behalf of a nursing home or FDD which is not properly chargeable as an expense of operations or maintenance. A capital expenditure does not include an expenditure for a housing project or a day care center or for a community-based residential facility not participating in the medical assistance program.

(7) "Center for the developmentally disabled" or "center" has the meaning specified in s. 51.01 (3), Stats.

(8) "Community-based residential facility" or "CBRF" has the meaning specified in s. 50.01 (1), Stats.

(9) "Concurrent review" means the review of competing applications for new beds in the same planning area.

(10) "Cost overrun" has the meaning prescribed in s. 150.01 (9), Stats., namely, an obligation exceeding the maximum capital expenditure authorized by an approval.

(11) "Date of notification" means the date on which the department publishes in a newspaper of general circulation and in the department's bureau of planning and development newsletter notice of receipt of and the proposed period for review of all applications being reviewed.

(12) "Day care center" means a facility where a person other than a relative or guardian provides care and supervision to adults or children on a nonresidential basis.

(13) "Department" means the department of health and social services.

(14) "Facility for the developmentally disabled" or "FDD" means a Wisconsin center for the developmentally disabled licensed under ch. H 34 [HSS 134] or a type of nursing home which, for the purpose of establishing and adjusting bed limits, is distinguishable from other nursing homes by primarily serving residents whose diagnosis is a long-term, chronic, developmental disability. Except as otherwise provided in rule by the department, "primarily serving," in this subsection, means that the facility's resident census, calculated on an annual basis, consists of the following minimum proportion of residents who have a developmental disability as their diagnosis and who require and receive active treatment:

(a) Fifty-one percent or greater for facilities licensed before the effective date of this chapter; and

(b) Eighty percent or greater for facilities newly licensed on or after the effective date of this chapter.

(15) "Health service area" means one of the areas of the state designated pursuant to 42 USC 300L for health planning purposes, with the boundaries indicated in Appendix A.

(16) "Health systems agency" or "HSA" means an agency designated under 42 USC 300L. In this chapter, where reference is made to a single HSA, the HSA is the agency within the area of which the proposed facility will be constructed or bed expansion or capital expenditure will occur.

(17) "Long-term care facility" means a facility for the developmentally disabled or other nursing home.

(18) "Material change in project scope" means the inclusion of beds not originally part of the application or a significant design change in the project which has a financial impact on the project.

(19) "Medical assistance" or "MA" means an assistance program under 42 USC 1396 and ss. 49.43 to 49.49, Stats.

(20) "New beds" means beds allocated for addition to the current licensed bed capacity of any planning area.

(21) "Nursing home" has the meaning specified in 50.01, Stats.

(22) "Person" means an individual, trust or estate, partnership, corporation, state or a political subdivision or agency of a state or local government unit.

(23) "Planning areas" means, for the purpose of nursing home planning and bed allocation, exclusive of FDDs, the health service areas. For purposes of FDD planning and bed allocation, "planning areas" means the health service areas, except for the centers for the developmentally disabled for which the entire state is a single planning area.

(24) "Replacement" means, in reference to a project, the construction of beds or related space to take the place of an equal or greater number of beds or related space in the same planning area.

(25) "Secretary" means the secretary of the department of health and social services.

(26) "Total replacement" or "totally replace" means the closing of a facility and the construction or licensure of an equal or lesser number of beds and ancillary space designed to replace that facility within the planning area.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.04 Statewide bed limit. (1) DEPARTMENT RECOMMENDATION. (a) *Nursing homes exclusive of FDDs.* The department shall biennially update and submit to the legislature statewide recommended bed limits for nursing homes exclusive of FDDs, taking into account programs the purpose of which is to reduce institutionalization of persons in long-term care facility settings. In developing the recommendation for a new statewide bed limit, the department shall add the following numbers for nursing homes exclusive of FDDs:

1. The number of beds licensed under subch. I of ch. 50, Stats., exclusive of beds in FDDs;

2. The number of beds approved under ch. 150, 1981 Stats., for which obligations have been entered into but which have not yet been licensed and have not had their certificates of need voided;

3. The number of new beds approved under s. 150.29, Stats; and

4. An allotment for new beds which shall be derived by dividing medical assistance reimbursement funds available for new beds as proposed in the following biennial budget by an estimated medical assistance allowable skilled care per diem rate. The resulting patient days shall be divided by the most recent available 3-year average percentage ratio of medical assistance residents to total residents. The patient days shall then be divided by the number of days in the year. This figure is the new allotment. Separate allotments shall be developed for nursing homes exclusive of FDDs. The new bed allotment in shall be the maximum number of new nursing home beds exclusive of FDDs which may be approved during the biennium for which the new bed limit is approved by the legislature.

(b) *Facilities for the developmentally disabled.* 1. The department shall biennially update and submit to the legislature statewide recommended bed limits for FDD beds, taking into account programs whose purpose is to reduce institutionalization of developmentally disabled persons. The new statewide bed limit for FDDs shall be established in the same manner as for nursing homes under par. (a) except that the new bed allotment for FDDs may not exceed the number of beds determined to be needed under s. HSS 122.05 (2) (a) and (b).

(2) INTERIM ADJUSTMENTS BY THE DEPARTMENT. Interim adjustments to the statewide bed limit may be made by the department for:

(a) *Conversion of community-based residential facilities.* The department shall adjust the total statewide bed limit, on a bed-for-bed basis, for each community-based residential facility currently certified as a medical assistance provider which obtains nursing home or FDD licensure in order to retain medical assistance certification. The effect of the adjustment may be to increase the statewide bed limit. If the number of licensed and approved nursing home beds is less than the statewide bed limit, the department shall count the CBRF beds under this paragraph toward the originally established statewide bed limit;

(b) *Code violations.* The department may decrease the statewide bed limit, on a bed-for-bed basis, to account for nursing home or FDD beds which are licensed but which are not set up or staffed due to life-safety or physical plant code violations. The department shall determine whether the situation is likely to be corrected within the forthcoming biennium. If the beds are not likely to be reopened within the forthcoming biennium, the department shall reduce the statewide bed limit by the number of beds currently out of circulation due to code violations;

(c) *Medical assistance waivers.* The department shall decrease the statewide bed limit, on a bed-for-bed basis, to account for nursing home or FDD beds closed under the medical assistance waiver specified in 42 USC 1396n(c) or under other medical assistance waivers specified in 42 USC 1396 to 1396n; and

(d) *Wisconsin center reductions.* The department shall decrease, on a bed-for-bed basis, the statewide bed limit for FDDs by each bed removed at the Wisconsin centers for the developmentally disabled as a result of the department's community integration program under s. 46.275, Stats.

(3) PUBLICATION OF ADJUSTMENTS. The department shall publish any adjustments to the statewide bed limit in the newsletter of the depart-

ment's bureau of planning and development and in a newspaper of general circulation. This publication shall occur by the 20th day of the month following the adjustment date.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.05 Bed allocation methodology. (1) NURING HOME BEDS EXCLUSIVE OF FDD BEDS. (a) *Distribution of the statewide allotment of new beds.* In distributing among planning areas new nursing home beds exclusive of FDD beds from the allotment under s. HSS 122.04 (1) (b) 4., the department shall proceed as follows:

1. Calculate for each planning area the population growth for the age cohorts under 65, 65 to 74, 75 to 84 and over 84 years of age for a 3-year period beginning in the calendar year for which the most current data on utilization of nursing homes are available;

2. Divide each planning area's population growth for each age cohort by the state growth in population for each cohort for those years to obtain the percentage that a planning area's growth represents of the total state growth by cohort;

3. Ascertain the statewide nursing home utilization percentage for each of the age cohorts in subd. 1 and multiply these by the new bed allotment for nursing homes exclusive of FDDs calculated pursuant to s. HSS 122.04 (1) (a) 4. to get the statewide allotment for each age cohort;

4. Multiply the statewide allotment for each age cohort by each planning area's percentage of state growth for its respective cohort calculated under subd. 2;

5. Add the 4 age cohort allotments for each planning area to determine the unadjusted new bed allotment for each planning area for nursing homes exclusive of FDDs;

6. Adjust downward the allotment for each planning area that has more beds per 1,000 residents age 65 and over than there are beds per 1,000 residents age 65 and over statewide by multiplying the unadjusted allotment for the planning area by the ratio of the number of existing and approved beds per 1,000 residents age 65 and over statewide to the number of existing and approved beds per 1,000 residents age 65 and over in the planning area as calculated from county level data, and subtracting the result from the unadjusted allotment. The result shall be the maximum new bed allotment for that planning area; and

7. Increase the unadjusted allotment for the remaining planning areas proportionately so that the total new bed allotments for all planning areas equal the total statewide new bed allotment calculated pursuant to s. HSS 122.04 (1) (b) 4. The result shall be the maximum new bed allotments for these planning areas.

(b) *Distribution of a planning area's allotment of new beds.* 1. The department shall distribute new nursing home beds exclusive of FDD beds within a planning area through application of a bed allocation priority model from which a priority list will be developed. The model shall be developed by the department and shall take into account current bed supply, utilization data, population trends and current supply and projected demand and expenditures for both institutional and noninstitutional long-term care resources.

2. The department shall develop weights for each component of the model in subd. 1 and shall publish its weighting system.

3. The weights for each component of the model shall be summed for each county to create a county-wide score. An application for new beds may be submitted using the procedure in s. HSS 122.06 only from those counties which have a total score falling below the statewide average. These counties shall constitute the bed allocation priority list.

4. The department may create service areas other than counties in the development of the model. New service areas shall be based on the most recently available utilization data in a planning area.

5. The department shall approve projects based on the priorities established in the model and on the review criteria and selection process under s. HSS 122.07.

6. a. The department shall update and revise the model every 2 years in consultation with the HSAs, the area agencies on aging and county social service departments and based on the most recent data available. Updates shall be based on changes in the actual values of the components of the model or in the weights given the components.

b. HSAs may annually recommend changes in the model to the department. All HSAs shall justify their recommendations based on updated data or computations or on local knowledge of need. An HSA shall document all public input into its recommendation, including governing body deliberations on the proposed revision. All proposed revisions shall reflect views of the public concerning the proposed change.

c. The department may accept or reject a proposed revision of the model. If it is accepted, the revised model shall supersede previous models adopted by the department. If the proposed revision is rejected, the department shall advise the HSA in writing of the reasons for the rejection.

d. An HSA recommendation for deletion of a county or service area from the priority list shall be accompanied by reasons for the recommendation.

7. If the score of a county or other service area is above the state average and the county or other service area is contiguous to a county or other service area on the bed allocation priority list, the department may include the county or other service area on the bed allocation priority list if there is documented evidence of problems regarding availability of or accessibility to nursing home and support services within the county or other service area developed by the department.

(c) *Redistribution of closed beds.* The department may distribute nursing home beds made available in the state as a result of facility closure or bed capacity reductions which were not closed under a medical assistance waiver or which were not replaced by CBRF beds converting to nursing home licensure. Available beds shall be redistributed to the planning area in which they were originally located.

(2) FDD BEDS. (a) The department shall not approve the addition of new beds to a state center for the developmentally disabled or other FDD licensed under subch. I of ch. 50, Stats., unless the beds are needed to serve persons who cannot adequately be served in an existing FDD,

another nursing home or in a less costly or less restrictive setting. Need for the beds shall be determined by the department through an objective analysis of the developmentally disabled population in the planning area after consultation with the appropriate HSA.

(b) The number of new beds allocated to the centers and other FDDs in an FDD planning area shall not exceed the number of persons requiring FDD care as determined under par. (a) for that planning area.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.06 Request for applications. (1) BEDS. (a) *New beds.* 1. After amendment of the statewide bed limit by the legislature, the department shall accept applications to fill the allotments for new beds, if any, for each planning area. Allotments shall be determined in the manner descibed in s. HSS 122.05. Application shall be made according to the following schedule:

a. In January for all counties located in health service area #2;

b. In April for all counties located in health service area #1;

c. In July for all counties located in health service areas #3, 4, and 7; and

d. In October for all counties located in health service areas #5 and 6.

2. The department shall request applications for new beds once from each planning area during the first half of each biennium. If the number of new beds approved for an area is less than the planning area's adjusted allotment, a second request for applications may be made during the second half of the biennium according to the schedule in par. (a).

(b) *Replacement beds.* The department shall annually accept applications to replace beds in a planning area which have been de-licensed but which were not closed under a medical assistance waiver or which were not replaced by CBRF beds which converted to nursing home licensure in order to retain medical assistance certification. Application shall be made according to the schedule in par. (a).

(2) FACILITY REPLACEMENTS AND CAPITAL EXPENDITURES OVER $600,000. The department shall annually request applications for projects to replace all or a portion of an existing nursing home or to make a capital expenditure of over $600,000 for a nursing home but which do not involve the addition of beds. The department shall request applications according to the schedule in sub. (1).

(3) CENTERS. The department shall annually solicit applications from the state centers for the developmentally disabled to relocate beds, renovate or replace beds or a facility, increase bed capacity or construct a new facility, or undertake a capital expenditure exceeding $600,000. The schedule for submitting applications shall be determined each year by the department.

(4) APPLICATION PROCESS. (a) *Notice requesting applications.* The request for applications shall be published in a major daily newspaper in each affected planning area on the first and second working days of the month during which requests are to be made. The notice shall state the deadline by which all applications are to be received.

(b) *Applications forms.* All applications shall be submitted on forms prescribed by the department. A prospective applicant may obtain the forms from the HSA serving the project's planning area or, if the project will be located outside the service area of any HSA, from the department.

Note: For copies of application forms for projects located outside HSA service areas, contact Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701-1808.

(c) *Period for accepting applications.* The department shall accept applications submitted within 60 days following publication of the request for applications, except as provided in sub. (10). All applications shall be submitted concurrently to the department and the appropriate HSA. The department shall return any application which:

1. Proposes to add new beds in a planning area, county or service area for which a request for applications was not made;

2. Exceeds the new bed allotment for the planning area;

3. Was submitted more than 60 days after the request for applications was published; or

4. Was submitted prior to publication of the request for applications.

(d) *Review for completeness.* 1. Each application submitted under subs. (1), (2) or (3) shall be reviewed by the department for completeness. An application shall be deemed incomplete if the applicant:

a. Fails to provide all of the requested information;

b. Provides the information in a manner which is illegible or otherwise unusable by the department; or

c. Provides information which contradicts or is not justified by other materials in the application.

2. The department, in consultation with the HSA, shall notify the applicant of the additional information requirements within 10 working days following receipt of the application by the department or by the applicable HSA, whichever date of receipt is later.

3. The applicant shall provide the required additional information within 30 days following the closing date for accepting applications.

4. The department shall return all applications for which additional information has not been received by the deadline established in subd. 3.

5. Except as provided in subd. 4., the department shall declare all applications complete 60 days after the date of publication of the request for applications, or 90 days from that date if an application under sub. (1), (2) or (3), including any application under sub. (1) undergoing concurrent review, was originally declared incomplete and the additional information requested by the department was received within 30 days following the closing date for accepting applications.

Note: Upon written request, the department will provide technical assistance to any small business, as defined in s. 227.016 (1) (a) Stats., or other small organization with fewer than 25 full-time employes or annual revenues of less than $2,500,000 regarding application materials and procedures. Requests should be sent to the Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701-1808.

(5) BEGINNING OF REVIEW PERIOD. The department shall publish in the newsletter of the bureau of planning and development and in a major daily newspaper in each affected planning area a list of all complete applications received under sub. (1), (2) or (3) within 20 days after the applications are declared complete. The review period for all of these applications shall begin on the publication date of the list. No person submitting an application for new beds may revise the cost or scope of the proposal after a notification of completeness has been made without the written consent of the department.

(6) HSA REVIEW. (a) *HSA procedures.* HSAs may develop their own review procedures for purposes of making recommendations to the department. These procedures shall be consistent with the procedures and criteria described in this section.

(b) *Public meeting.* Upon the request of any affected party, the applicable HSA shall hold a public meeting within 60 days following publication of the list of complete projects submitted under sub. (1), (2) or (3). This meeting shall be used to elicit testimony from affected parties about projects under review. The applicable HSA shall maintain minutes or another record of the testimony and shall forward a copy to the department when it submits to the department its formal recommendations under par. (c). In areas not served by an HSA, the department shall conduct the public meeting upon the request of an affected party. All requests for a public meeting shall be received by the HSA, or by the department if there is no HSA, within 10 days after publication of the list of complete applications. The public meeting shall be held prior to any formal recommendation by the HSA or an initial finding by the department.

(c) *Recommendation.* The HSA shall review each application and base its recommendation on the consistency of the application with the criteria in s. HSS 122.07. HSAs shall submit to the department their formal recommendations to approve or disapprove applications within 60 days following publication of the complete applications list, unless extended by mutual consent of all applicants or unless the review cycle is extended pursuant to sub. (8).

(7) DEPARTMENT REVIEW AND INITIAL FINDING. (a) The department shall review applications for their consistency with the criteria in s. HSS 122.07 and shall issue an initial finding to approve or reject an application within 75 days following publication of the complete applications list, unless all applicants undergoing concurrent review agree to an extension or the review cycle is extended under sub. (8). In no case may the initial finding be made prior to receipt by the department of the appropriate HSA's recommendation or less than 60 days after publication of the complete applications list.

(b) The department's initial finding shall be based upon a comparative analysis of all applications undergoing concurrent review using the criteria specified in s. HSS 122.07.

(8) EXTENSION. The department may extend by 60 days the review cycle of all projects undergoing concurrent review under sub. (1), if it finds that completing reviews within the cycle specified in sub. (7) is not feasible due to the volume of applications received from any planning area.

(9) REQUEST FOR HEARING. An adversely affected applicant or HSA may file a written request for a public hearing under s. HSS 122.08 within 10 days after the date of the department's initial finding under sub. (7). If no request for a hearing is made, or if a request is received after the 10-day limit, the department's initial finding shall be the department's final decision. A timely request for hearing from an applicant undergoing concurrent reveiw shall preclude issuance of an approval for a competing concurrent application until a final decision is issued by the secretary or a designee. Hearings shall be held in the manner prescribed in s. HSS 122.08.

(10) EXPEDITED REVIEW. (a) *Conditions for expedited review.* An application involving a capital expenditure of over $600,000 is subject to the requirements of this subsection rather than subs. (2) to (9) if:

1. The project does not increase the bed capacity of or totally replace an existing nursing home and the project was developed pursuant to a department-approved plan of correction to remedy code-related physical plant deficiencies. Applications submitted to correct code violations shall provide evidence of the violations and approved plan of correction and shall not go beyond what is necessary to correct those deficiencies; or

2. The application concerns a cost overrun on a previously approved project.

(b) *Timing of application.* An application under par. (a) may be submitted at any time on forms prescribed by the department provided that at least 30 days notice has been given to the department and the HSA of a person's intent to submit the application and the applicant has received written authorization from the department to submit the application.

(c) *Review period.* Applications which are subject to this subsection shall be reviewed by the department within 60 days of receipt of a complete application.

(d) *Completeness.* 1. The department, in consultation with the HSAs, shall have 5 working days to determine if the application is complete and, if incomplete, to forward a request for additional information to the applicant. An incomplete application is one in which:

a. The applicant has failed to provide requested information;

b. The information is illegible or unreadable in the form submitted; or

c. The application contains information contradicted or unjustified by other materials in the application.

2. Applications that were originally declared incomplete shall be declared complete on the date of receipt of all additional information requested by the department.

(e) *HSA review and recommendation.* The applicable HSA shall submit its recommendation on the application within 55 days from the date of determination of completeness. The HSA shall review each application and base its recommendation on consistency of the application with the criteria in s. HSS 122.07. The public meeting requirement is waived for applications reviewed under this subsection.

(f) *Department's initial finding.* The department shall issue its initial finding to approve or reject the application within 60 days following receipt of a complete application. The initial finding shall be based on the criteria specified in s. HSS 122.07.

(g) *Hearing.* Any adversely affected applicant or HSA shall have 10 days after the date of the initial finding to request a public hearing to challenge the initial finding on an application. Public hearings shall be held in the manner specified in s. HSS 122.08. If no requests for a hearing are made or if they are received after the 10-day limit, the initial finding becomes the department's final action.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.07 Review criteria and selection process. (a) REVIEW CRITERIA. The department shall use the criteria set out in this subsection in its review of all applications for project approval. Cost containment shall be the first priority in applying these criteria. The department may not approve a project unless the applicant has demonstrated that:

(a) The project is consistent with the state health plan and other long-term care support plans developed by the department.

(b) Medical assistance funds appropriated are sufficient to reimburse the applicant for providing nursing home or FDD care.

(c) The cost of renovating or replacing the facility or adding new beds is consistent with the cost of similar nursing home or FDD projects recently approved by the department and is reasonable based on independent analyses using industry-recognized cost-estimating techniques, and:

1. The proposed cost per bed for total facility replacement or for new facilities and beds does not exceed the following per bed cost expressed in the formula for nursing homes other than FDDs, that C is less than or equal to 1.2 (S) (F) and in the formula for FDDs and for other nursing homes in which more than 50% of the residents calculated on an annual basis have a physical illness as their primary diagnosis and also have a mental illness, either of which would independently require nursing care, that C is less than or equal to 1.3 (S) (F).

a. "C" in this formula means maximum cost per bed using the capitalized project costs, including site improvements, buildings, fixed equipment, interest during construction and professional and financing fees, calculated to the midpoint of construction.

b. "S" equals $31,000.

Note: $31,000 is the statewide cost per bed for the base year 1983.

c. "F" in this formula means inflation factor.

Note: The department uses the inflation estimates published in *Engineering News Record's* Building Cost Index.

2. The proposed equivalent cost per bed for renovation and partial replacement projects does not exceed the per bed cost as expressed in the formulae for nursing homes other than FDDs, the C_e is less than

$$\frac{1.2\ (S)\ (F)}{35}$$

and in the formula for FDDs and for other nursing homes in which more than 50% of the residents calculated on an annual basis have a physical illness as their primary diagnosis and also have a mental condition, either of which would independently require nursing care, that C_e is less than $\frac{1.3\ (S)\ (F)}{35}$.

a. "C_e" in this formula means the maximum equivalent per bed cost, calculated as follows:

$$C_e = \frac{\text{capitalized project costs}}{\text{(remaining useful life of affected areas) (total beds)}} + \frac{\text{current annual depreciation}}{\text{total beds}}$$

b. "S" and "F" in this formula are as defined in subd. 1.

Note: The maximum capital allowances calculated pursuant to par. (c) are not to be used by applicants as the expected cost of projects. Applicants are encouraged to seek less costly alternatives to the state maximums and all applications will have to meet all review criteria before undergoing the selection process in sub. (2).

(d) The project represents the most cost-effective, reasonable and feasible alternative for renovation or replacement of a facility, for the addition of beds to a facility or for the construction of a new facility.

1. The applicant shall provide an analysis which clearly defines all other reasonable alternatives such as:

a. Variations in functional program;

b. Renovation instead of replacement;

c. Reductions in bed capacity;

d. Variations in facility design; and

e. Variations in methods or materials of constuction.

2. The analysis shall include an evaluation of the existing physical plant.

3. The analysis shall include a life-cycle cost analysis for each alternative studied, using forms provided by the department. In this subsection "life cycle" means the number of years for which alternatives are compared, and "life-cycle cost" means all relevant costs associated with a project during the project's defined life cycle.

Note: Copies of the life-cycle cost analysis form will generally be included in the application materials. They may be obtained separately from the Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701-1808.

4. The department may independently develop its own alternatives to compare with those developed by the applicant.

(e) A need for additional beds exists in the planning area in which the project would be located. No new beds may be approved in any planning area if their addition would exceed the planning area's adjusted allocation, calculated pursuant to s. HSS 122.05.

(f) The project is consistent with local plans for developing community-based long-term care services. These plans shall include those developed by HSAs and local units of government.

(g) Necessary health care personnel, and capital and operating funds for provision of the proposed nursing home services are available, as follows:

1. The project will meet minimum staffing and financial requirements developed by the department pursuant to ch. H 34 [HSS 134] or HSS 132;

2. The facility will be located to assure reasonable access to nursing staff, emergency medical care, physician coverage, acute care services and ancillary services; and

3. Sufficient cash resources and cash flow exist to pay operating and initial start-up costs.

(h) The project is financially feasible, capable of being undertaken within one year of approval and completed within a reasonable period of time beyond the one-year approval period, as evidenced by:

1. The applicant's demonstration of ability to secure adequate funds to finance the project. The applicant shall have adequate capacity to incur the debt associated with the project. Applicants shall have the ability to pay long-term debt through their present and future cash flow and profitability positions;

2. The availability of financing at average or below market rates for the class of home during the period of validity of the approval. Classes of homes are governmental, proprietary and nonprofit. Projects relying on sources of financing which historically take longer to process than the period of validity of an approval shall be rejected unless there is clear and definite proof supplied by the applicant that the funding source will be able to make adequate funds available within the period of validity of the approval; and

3. The reasonableness and attainability of the applicant's construction schedule.

(i) Appropriate alternative methods for providing nursing home or FDD care are unavailable in the planning area. Alternative methods shall be deemed unavailable if the project is consistent with long-term care initiatives developed by the department.

(j) The existing and proposed quality of care is satisfactory, as determined by:

1. The department's investigations. No approvals may be granted to any person who owns or operates a facility with one or more uncorrected class A or class B violations unless the project is specifically designed to remedy those violations, or to any person who owns or operates a facility against which a medical assistance or medicare decertification action is pending;

2. The department's review of materials submitted by the applicant, which may include an independent performance evaluation of an existing facility, an evaluation of other homes owned and operated by an applicant seeking approval for a new facility, and patient satisfaction surveys, where available;

3. Recommendations or comments from affected parties regarding the quality of care in facilities owned and operated by the applicant; and

4. For applications proposing replacement or relocation of beds, approval by the department of a plan for the placement or relocation of persons residing in those beds, based on the census of the FDD or other nursing home at the time of submission of the application.

(k) The project is consistent with all applicable federal, state and local licensing, physical plant, zoning and environmental laws.

(2) RANKING AND SELECTION PROCESS. (a) Applications for new beds which meet all of the criteria in sub. (1) shall be subject to the following final selection process:

1. Applications shall be ranked in the order of their proposed per diem rates, beginning with the lowest and ending with the highest. Rates within one percent of each other shall be considered equal for purposes of ranking;

2. The department shall approve projects in the order of their ranking until all beds allotted to a planning area are distributed; and

3. The department may approve an application proposing a higher per diem rate than others undergoing concurrent review if the applicant can demonstrate that the application would substantially resolve a significant problem identified in the state health plan and the HSA plan with respect to:

a. The existing distribution of beds in the county in which the project would be located, or in contiguous counties;

b. The need to serve a special diagnostic group of inpatients in the planning area or county in which the project would be located; or

c. The existing distribution of population within the planning area or county in which the project would be located.

(b) Applications for renovation proposals, replacement facilities and capital expenditures over $600,000 which do not affect bed capacity and which meet all criteria in sub. (1) shall be approved unless the per diem rates proposed as a result of the project are inconsistent with those of similar FDD or other nursing home projects recently approved by the department.

(c) In applying pars. (a) and (b), the department shall consider the recommendations of HSAs and the comments of affected parties.

(d) The department may not approve new beds if this would cause the statewide bed limit to be exceeded.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.08 Hearing process. (1) RIGHT TO A HEARING. An applicant whose project is rejected or any adversely affected HSA may request a public hearing to review the department's initial finding.

(2) REQUEST FOR A HEARING. (a) An applicant or HSA desiring a public hearing shall submit a written request, no later than 10 days after the issuance of the initial finding, to both the department's division of health

and the department's office of administrative hearings. The request shall identify the writer as an applicant or an adversely affected HSA.

Note: The mailing address of the Department's Division of Health is P.O. Box 309, Madison, Wisconsin and the mailing address of the Office of Administrative Hearings is P.O. Box 7875, 119 King Street, Madison, Wisconsin 53707.

(b) The applicant or HSA requesting the hearing shall identify the criteria at issue no later than 20 days after the issuance of the finding.

(3) PUBLIC HEARING. (a) *Start of hearing process.* The department shall commence the hearing process within 30 days after receiving a request under sub. (2), or 30 days following the last request in the event of a concurrent review, unless all parties to the hearing consent to an extension of this period. The hearing process shall begin upon appearance of the parties before the hearing examiner as part of a prehearing conference.

(b) *Applications undergoing concurrent review.* All applications undergoing concurrent review shall be considered at one hearing.

(c) *Location.* All public hearings and prehearing conferences shall be held in the city of Madison unless any party demonstrates that this would impose an undue hardship on that party.

(d) *Legal issues.* A public hearing under this subsection shall consist of a review of the department's initial finding to approve or reject the project. The only issues in the hearing are whether the department's initial finding was:

1. Contrary to the weight of the evidence on the record when considered as a whole;

2. Arbitrary and capricious; or

3. Contrary to law.

(e) *Prehearing conference.* 1. At least 14 days prior to the public hearing, a prehearing conference shall be held. The purpose of the prehearing conference shall be to consider:

a. The possibility of obtaining admissions of fact and documents which will avoid unnecessary proof; and

b. The scheduling of the submission of names of witnesses to be called and the subject matter of testimony to be presented at the hearing.

2. The hearing examiner may issue prehearing orders:

a. Directing the order of presentation;

b. Limiting evidence and the number of witnesses;

c. Requiring that evidence be presented in written form and exchanged among parties prior to the hearing; and

d. Determining whether a party as defined under s. 227.01 (6), Stats., has standing to participate in the hearing.

3. The hearing examiner shall prepare a memorandum summarizing the actions taken at the conference.

(f) *Procedures for conducting the hearing.* 1. Issues raised at the hearing shall be limited to the review criteria cited as grounds for disapproval in the initial finding. Criteria not identified in the initial finding are deemed met or not applicable. Evidence may be received which relates to non-contested criteria only to the extent the evidence is relevant to contested criteria. In appeals by the HSA, the issues shall be limited to those criteria upon which the HSA's recommendation and the initial finding differ and to the reasons for differences as cited in the initial finding.

2. Except as provided in subd. 3, evidence admitted at the hearing shall be limited to:

a. The application, supporting documents which were submitted with the application, and additional information submitted in response to the department's requests;

b. The staff analysis, initial finding and supporting documents relied upon in making the initial finding;

c. The record of the public meeting under s. 150.35 (2), Stats. and s. HSS 122.06 (6), if any, the HSA's recommendation and supporting documents relied upon in making the recommendation; and

d. Cross-examination of persons preparing or making statements contained in the documents under subpars. a to c.

3. Parties may be allowed to present additional evidence only to the extent the additional evidence is directly responsive to and made necessary by the evidence presented by any other party to the proceedings.

4. Persons preparing or making statements contained in the application, staff analysis, initial finding, recommendation or supporting documents shall be available for cross-examination, unless cross-examination is waived by opposing parties, and may give rebuttal testimony. Witnesses giving direct oral testimony shall be subject to cross-examination in the same manner as other witnesses.

5. Any party for the proceeding may be represented by counsel and present evidence and conduct cross-examinations subject to the provisions of subd. 2.

6. The examiner conducting the hearing may question all witnesses and take administrative notice of all judicially cognizable facts.

7. Evidence shall be duly offered and made part of the case record.

8. Any party adversely affected by a ruling may make an offer of proof which shall be made part of the record.

9. An applicant whose project is rejected or any adversely affected HSA has the burden of going forward.

(g) *Hearing examiner duties.* The hearing examiner shall:

1. Make all ruling as to evidence, testimony and official notice;

2. Set the order for examination and cross-examination of witnesses;

3. Administer oaths and affirmations;

4. Prepare written and oral summaries of cases heard;

5. Prepare a recommendation for the secretary, consisting of findings of fact, conclusions of law and a recommended course of action; and

6. Adjourn the hearing to a specific time, date and place, if appropriate.

(h) *Hearing record.* A stenographic record shall be made in all public hearings. If any party, including the department, wants a transcript or a portion of the transcript, that party shall make arrangements with the court reporter and shall pay whatever costs are agreed upon for making the transcript.

(i) *Posthearing oral arguments and briefs.* 1. Following presentation of the testimony, posthearing briefs may be filed by the applicant, the department and any interested party. Parties submitting briefs shall file copies within a reasonable time specified by the hearing officer.

2. The examiner may permit oral arguments in lieu of posthearing briefs. Any party that wishes to file a written brief shall be permitted to do so.

(j) *Close of hearing.* A hearing is closed when the evidentiary record is closed and any period established by the hearing officer for filing of briefs has elapsed. If the briefing period has expired and no brief of any party has been filed, the department may proceed to its final decision.

(k) *Ex parte communication.* The ex parte communication restriction is set forth in s. 227.13 (2), Stats., including sub. (1) (d) shall apply to projects for which a public hearing has been requested.

(l) *Proposed decision.* (a) Unless designated by the secretary as the final decision maker, the examiner shall issue a proposed decision containing findings of fact, conclusions of law, and a recommendation for action to be taken. A copy of the proposed decision shall be served on each party. In any hearing under this section, the examiner shall establish a comment period during which the parties may submit comments pertaining to the proposed decision. At the close of the comment period, the parties' submissions shall be forwarded to the secretary or a designee of the secretary along with the proposed decision.

(4) FINAL DECISION. (a) The final decision shall then be made by the secretary or the secretary's designee. In the event a designee is chosen, all parties shall be notified.

(b) A final decision may be issued to either approve or deny the application or to approve the application with conditions. If the proposed decision is deemed incomplete on any issue identified in the initial finding, the case may be remanded back to the examiner for the taking of further testimony.

(c) The secretary or designee of the secretary may ask all parties to the proceedings to present oral arguments before he or she makes a final decision.

(5) BURDEN OF PROOF. Each applicant or adversely affected HSA at any hearing under this section has the burden of proving, by clear and convincing evidence, that the department's initial finding was contrary to the weight of evidence on the record when considered as a whole, arbitrary and capricious, or contrary to law.

(6) REHEARING. 1. A petition for rehearings shall meet the requirements set forth under s. 227.12, Stats. The department shall review a petition for rehearing as provided in s. 227.12, Stats.

2. A petition for rehearing shall set forth the particular grounds for the relief sought. Copies of the petition shall be served on all parties of record.

(7) REQUIREMENTS FOR JUDICIAL REVIEW. Petitions for judicial review shall be filed in the circuit court as specified in s. 227.16 (1) (a), Stats., within 30 days after the department issues its final decision, and shall be served on the department and other parties to the proceeding.

Note: The scope of judicial review is as provided in s. 277.20, Stats., and the record consists of the material specified in s. 150.43, Stats.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 122.09 Enforcement. (1) REPORTING REQUIREMENTS. (a) Each holder of an approval shall submit to the department, on forms provided by the department, regular progress reports which describe the current status of the project. These reports shall include or shall have attached:

1. An up-to-date copy of the proposed building plans;

2. An up-to-date copy of the estimate of construction costs or copies of bids for construction costs, or both;

3. An up-to-date statement of the total project costs;

4. Up-to-date copies of current financing commitment documents, by source of funds; and

5. A narrative description of the current status of the project, specifying any material changes in project scope, cost, proposed per diem rates or design anticipated by the approval holder.

(b) The applicant shall automatically send these status reports to the department according to the following schedule:

1. At the completion of design development drawings;

2. On receipt of bids prior to the start of construction;

3. At 6-month intervals throughout the construction period; and

4. At project completion.

(c) If an approval holder fails to submit the required information according to the schedule in par. (b), the department shall not approve any cost overrun that is incurred or a material change in project scope from that in the original approval.

(d) The department shall review each status report within 5 working days of submittal and issue a determination to the approval holder to proceed with the project unless the status report indicates a potential cost overrun or material change in project scope. The department shall advise the approval holder if additional review under this chapter is required.

(2) COST OVERRUNS. (a) Cost overruns are subject to approval by the department before they are incurred.

(b) Approval holders shall report to the department any anticipated cost overrun.

(c) 1. An approval holder who identified a cost overrun on an approved project shall submit another application for review in the manner described in s. HSS 122.06 (10).

2. The original approval is not affected by the submission of an application involving a cost overrun on a previously approved application. If the department approves the overrun, the original approval shall be amended accordingly. If the department does not approve the overrun, the original approval shall be unchanged.

(d) The department shall not approve an application for a project involving a cost overrun on a previously approved application:

1. If an obligation exceeding the capital expenditure maximum was incurred by the approval holder before the holder notified the department of the cost overrun;

2. If the cost overrun is based on inflation rates which exceed actual rates reported in the *Engineering News Record's* Building Cost Index;

3. If the cost overrun is the result of a material change in the scope or size of an approved project; or

4. If the cost overrun results in a project that would not be approved under s. HSS 122.07 (1) or (2).

(3) CIVIL FORFEITURES. (a) The department shall use the following schedule for determination of forfeitures resulting from approved cost overruns on previously approved projects:

1. A cost overrun resulting from the actual inflation rate which exceeds the rate projected in the approved application or is less than 10 percent of the approved project cost or $300,000, whichever is greater, shall be subject to a forfeiture equal to 10% of the overrun.

2. A cost overrun which is more than 10% or more of the project cost or $300,000, whichever is greater, shall be subject to a forfeiture equal to 15 percent of the overrun; and

3. If a person incurs a second cost overrun on an approved project, the department shall assess a forfeiture equal to 30% of the overrun.

(b) 1. Where a project is subsequently approved after being initiated without departmental approval, the person operating the project shall be subject to a single forfeiture using the following schedule:

a. For an expenditure greater than $600,000 but no more than $660,000, the person operating the project shall pay a forfeiture equal to 10% of the expenditure exceeding $600,000;

b. For an expenditure greater than $660,000 but no more than $900,000, the person operating the project shall pay a forfeiture equal to 15% of the expenditure exceeding $660,000, plus the dollar amount specified in subd. 1; and

c. For an expenditure greater than $900,000, the person operating the project shall pay a forfeiture equal to 50% of the expenditure exceeding $900,000, plus the dollar amounts specified in subds. 1 and 2;

2. If the capital expenditure limits in s. 150.21 (3) and (4), Stats., are adjusted under s. 150.15, Stats., the capital expenditures listed in subd. 1. shall be automatically adjusted proportionately.

(c) 1. The department may not approve a cost overrun for a project subject to a forfeiture under pars. (a) or (b) until the forfeiture has been paid.

2. The department may not subsequently approve a project which was initiated without departmental approval and which involved construction of space designed to be utilized for a future FDD or other nursing home or to increase the bed capacity of a FDD or other nursing home.

(4) REPEAT VIOLATIONS. (a) The department shall reject an application for approval of a project from any person who has incurred 2 penalties under this chapter within a 5-year period, except for penalties assessed for cost overruns caused by the actual inflation rate exceeding the inflation rate stated in the original application or caused by code corrections mandated by the department as part of an approved plan of correction issued after the original approval.

(b) The department shall impose deadlines for compliance with any approval granted to a repeat violator. Failure to meet the deadlines shall result in voiding of the approval.

(5) MEDICAL ASSISTANCE LINKAGE. (a) 1. Any person submitting an application under this chapter shall state in the applicating the medical assistance rates anticipated for the first full year of operation following completion of the project or licensure of new beds. These rates shall be the maximum allowable reimbursement granted by the department for the first full year of operation. If the medical assistance reimbursement formula generates per diem rates which are less than those stated in the application, the lower rates shall prevail.

2. For the purposes of rate calculations for renovation projects, the useful building life used for depreciation shall be the same as that stated in the application in s. HSS 122.07 (1) (c) 2. for calculating equivalent cost per bed. The useful life selected shall remain constant for the life of the building.

(b) Any person submitting an application for approval of a cost overrun under sub. (2) (c) shall state the impact on medical assistance per diem rates stated in the original application. If approved, the rates in the new application shall be the medical assistance per diem rates for the first full year of operation following completion of the project or licensure of new beds.

(6) TRANSFER OF APPROVAL. An approval is issued in the name of the person submitting an application. Any person who takes a partner after receiving a project approval shall retain an equal or greater financial interest in the project for the approval to remain valid. The sale, lease or donation of a nursing home before the completion or licensure of a project at that nursing home voids the approval.

(7) VALIDITY OF APPROVAL. (a) An approval is valid for one year from the date of issuance unless extended under sub. (8).

(b) The department shall revoke an approval at the end of the period of validity of an approval if the status reports required under sub. (1)

indicate that permanent financing has not been obtained, an obligation has not been incurred for the entire project or 20% of the approved project cost, including fees, has not been spent. An approval holder has obtained permanent financing when:

1. The interim or long-term mortgage has been executed by all parties, and the proceeds are available to the borrower in an amount sufficient to complete the project; or

2. The bonds have been sold, either publicly or privately, and the proceeds are available to the borrower in an amount sufficient to complete the project.

(8) REQUEST FOR EXTENSION OF PROJECT VALIDITY. (a) A person may request an extension of up to 6 months in the period of validity of an approval. The request shall include documentation of the following:

1. Names of all contractors, subcontractors or suppliers against whom a job action was incurred or a bankruptcy was filed;

2. Dates on which bankruptcies or strikes occurred and the resulting length of delay in project implementation, and dates on which a fire or natural disaster occurred, the extent of damage, and the resulting length of delay in project implementation; and

3. Any cost overruns anticipated as as result of the extension.

(b) Cost overruns on projects for which an extension has been granted shall be reviewed in the manner described in s. HSS 122.06 (10).

(c) The department may grant an extension only if the project is significantly delayed or damaged by fire or natural disaster, or if a strike against or bankruptcy of a contractor, subcontractor or major supplier previously committed to the project occurs.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

APPENDIX A

Designated Health Service Areas in Wisconsin Under 42 USC 300L [HSS 122.03 (15)]

Health Service Area #1

Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk counties

Health Service Area #2

Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha counties

Health Service Area #3

Calumet, Fond du Lac, Green Lake, Marquette, Outagamie, Waupaca, Waushara, Winnebago counties

Health Service Area #4

Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan counties

Health Service Area #5

Barron, Buffalo, Chippewa, Clark, Crawford, Dunn, Eau Claire, Jackson, La Crosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, Trempealeau, Vernon counties

Health Service Area #6

Adams, Florence, Forest, Juneau, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, Wood counties

Health Service Area #7

Ashland, Bayfield, Burnett, Douglas, Iron, Price, Sawyer, Washburn counties