3701-12-23 **Long-term care facilities and beds.**

(A) Except as otherwise specifically provided in this rule or in another rule of this chapter, the director shall apply all of the criteria prescribed by this rule when reviewing an application for a certificate of need that relates to an existing or proposed long-term care facility, including an application for:

(1) The establishment, development, or construction of a new long-term care facility;

(2) The replacement of an existing long-term care facility;

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;

(4) Either of the following changes in long-term care bed capacity:

(a) An increase in bed capacity; or

(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site.

(5) Any change in the health services, bed capacity, or site, or to conduct a reviewable activity that is not in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted; or

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds.

(B) The director shall utilize the following formula to determine the number of long-term care beds needed for each county for the comparative review process prescribed in section 3702.593 of the Revised Code:

(1) State bed need rate calculation:

Total statewide inpatient days ÷ total bed days available of these facilities = statewide long-term care bed occupancy rate

Statewide long-term care bed occupancy rate x total statewide long-term care

bed supply = total statewide number of beds occupied

Total statewide number of beds occupied ÷ ninety per cent = total statewide number of beds needed

(Total statewide number of beds needed ÷ projected statewide population aged sixty-five and older) x one thousand = state bed need rate

For purposes of this rule:

Total statewide inpatient days means: The sum of inpatient days for all facilities identified by facility type as "Nursing Facility" that filed a medicaid cost report for the calendar year that is two years prior to the year in which a bed need is published for the first comparative review process and the first phase of a four year comparative review process.

Total bed days available of these facilities means: The sum of the long-term care bed capacity for each nursing facility that is multiplied by the number of calendar days in the reporting year.

Total statewide long-term care bed supply means: Utilize the most recent long-term care bed supply per county that is determined by the director. The long-term care bed supply per county shall include licensed nursing home beds, beds certified as nursing facility or skilled nursing facility under Title XVIII or XIX of the Social Security Act. 49 Stat. 620 (1935), 42 U.~~W~~S.C. 301, as amended, beds in a county home or county nursing home as defined in section 5155.31 of the Revised Code that were ~~in operation on July 1, 1993 as documented to the director by the operator of the home by November 1, 2009~~timely and properly reported as long-term care beds pursuant to section 5155.38 of the Revised Code, and beds held as "approved" beds under an approved certificate of need. The long-term care bed supply shall not include hospital beds that are registered as special skilled nursing or swing beds or beds in a county home or county nursing home that were not timely documented to the director as being in operation on July 1, 1993 and are not eligible for licensing as nursing home beds.

Projected statewide population aged sixty-five and over means: Based on the Ohio department of development's projections for the year that is at least five years after the year in which a bed need is published for the first comparative review process and for the first phase of a four year comparative review process.

(2) County bed need calculation:

(Projected county population aged sixty-five and older ÷ one thousand) x

state bed need rate = number of beds needed for the county

Number of beds needed for the county - bed supply for the county = bed need or excess for the county

For purposes of this rule:

Projected county population aged sixty-five and older means: The projections for each county that were used in determining the projected statewide population aged sixty-five and over.

Bed supply for the county means: The bed supply for each county that was used in determining the total statewide long-term care bed supply.

(C) If the formula projects a bed need for a county with an average annual occupancy rate of less than eighty-five per cent, the director shall find that there is no bed need.

(D) If the formula projects a bed excess for a county with an average annual occupancy rate of greater than ninety per cent, the director may approve an increase in beds equal to up to ten per cent of the long-term care bed supply for that county.

(E) Except as provided in paragraph (D) of this rule, if the formula projects a bed excess of one hundred beds or less for a county, the director shall find that there is no excess or, if the formula projects a bed excess of more than one hundred beds, the director shall find that there is a bed excess for the projected number of beds less one hundred.

(F) By April 1, 2010, April 1, 2012, and every four years thereafter, the director shall publish on the department of health's website the following:

(1) Each county with a bed need and the number of beds needed for the county: and

(2) Each county with a bed excess and the number of excess beds for the county.

(G) By April 1, 2014 and every four years thereafter, the director may publish on the department of health's website, each county with a remaining bed need and the number of beds still needed for the county.

The director's decision to publish a remaining bed need for a county shall be based on the number of surrendered beds statewide, pursuant to paragraph (M)(4) of this rule, the remaining county bed need, and the county's long-term care bed occupancy rate.

Remaining bed need calculation:

Published bed need from the first phase of the four year comparative review process - the number of beds approved for a county from the first phase of the four year comparative review process - the number of beds approved for a county from a contiguous county after calculating the bed need for the first phase of the four year comparative review process to calculating the remaining bed need = remaining bed need for the county.

(H) The director shall not grant a certificate of need under this rule unless the application contains the following items:

(1) A copy of an agreement with an existing state or county-sanctioned preadmission screening program that provides that the entire facility will participate in the program. If no program exists in the relevant county at the time of application, the applicant shall state in the application that the facility will participate in any program that becomes available within eighteen months after services begin to be offered as the result of the project;

(2) Documentation that the project will comply with the following requirements, as applicable:

(a) For homes required to be licensed under Chapter 3721. of the Revised Code, the requirements for licensure under Chapter 3721. of the Revised Code and Chapter 3701-17 of the Administrative Code;

(b) For hospital long-term care beds, beds in county homes as defined in section 5155.31 of the Revised Code that are long-term care facilities as defined in this chapter, and long-term care beds in a long-term care facility, the requirements for certification as a nursing facility or skilled nursing facility under Title XVIII or XIX of the Social Security Act. 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

(I) The director shall not grant certificates of need for establishment, construction, or development of new long-term care facilities, including replacement facilities, with a long-term care bed capacity of less than fifty beds. The director may waive the criterion prescribed by this paragraph if the applicant demonstrates that the proposed facility of less than fifty beds can be operated in a cost-effective manner, and:

(1) The proposed facility's size is essential to serve a special health care need that otherwise will not be served, or will serve a special health care need in

accordance with current, evidence-based standards of care;

(2) The proposed facility is the only feasible alternative for cost-effective correction of physical plant deficiencies; or

(3) The proposed facility is part of a continuing care retirement or life care community and the application demonstrates the following:

(a) The applicant will be contractually obligated to provide long-term care to current residents of the continuing care retirement or life care community; and

(b) The continuing care retirement or life care community currently provides and will continue to provide preference in admission to contractual residents of the community.

(J) The director shall not grant certificates of need for new or replacement long-term care facilities of more than one hundred fifty beds or for bed additions to existing long-term care facilities if the resulting facility will have more than one hundred fifty beds, except for a facility to replace a single, existing long-term care facility. The director may waive the criterion prescribed by this paragraph if the applicant demonstrates that a facility of more than one hundred fifty beds is essential to serve a special health care need that otherwise will not be served and that the facility can be operated in an efficient manner without sacrificing quality care for its patients.

(K) In reviewing a certificate of need application under this rule, the director may examine and consider, in accordance with this paragraph, any state or federal records relating to the licensure under Chapter 3721. of the Revised Code or, if applicable, the participation as a provider under Title XVIII or XIX of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, of any long-term care facilities owned, operated, or managed by the applicant, the owner or the operator of the long-term care facility to which the application relates, or by any principal participant, as defined in paragraph (II) of rule 3701-12-01 of the Administrative Code, in an entity which is or will be the applicant, owner, or operator. The application shall contain a list of all relevant long-term care facilities with dates of ownership, operation, or management. The director also may consider records pertaining to ownership or operation by these persons of long-term care facilities in other states.

(1) The director may deny the certificate of need if ~~the records reveal that a relevant long-term care facility's license has been revoked or its certification involuntarily denied, terminated, or not renewed, that a state licensing, survey, or medicaid agency or the United States department of health and~~

~~human services has issued written notice proposing to take such an action or has imposed other sanctions, or that the facility has or had serious deficiencies that jeopardize the life, health, safety, or welfare of the residents or seriously limit the facility's capacity to provide adequate care, particularly if governmental action was based upon repeated citation of the same or similar deficiencies.~~:

(a) The existing health care facility in which the beds are being placed has one or more waivers for life safety code deficiencies, one or more state fire code violations, or one or more state building code violations, and the project identified in the application does not propose to correct all life safety code deficiencies for which a waiver has been granted, all state fire code violations, and all state building code violations at the existing health care facility in which the beds are being placed; or

(b) During the sixty month period preceding the filing of the application, a notice of proposed license revocation was issued under section 3721.03 of the Revised Code for the existing health care facility in which the beds are placed or a nursing home owned or operated by the applicant or a principal participant; or

(c) During the period that precedes the filing of the application and is encompassed by the three most recent surveys of the existing health care facility in which the beds are being placed any of the following occurred:

(i) The facility was cited on three or more separate occasions for final, nonappealable actual harm, but not immediate jeopardy deficiencies;

(ii) The facility was cited on two or more separate occasions for final, nonappealable immediate jeopardy deficiencies;

(iii) The facility was cited on two separate occasions for final, nonappealable actual harm, but not immediate jeopardy deficiencies and on one occasion for a final nonappealable immediate jeopardy deficiency; or

(iv) More than two nursing homes owned or operated in this state by the applicant or a principal participant or, if the applicant or a principal participant owns or operates more than twenty nursing homes in this state, more than ten per cent of those nursing homes, were each cited during the period that precedes the filing of the application for the certificate of need and is encompassed by the three most recent standard surveys of the nursing homes that were so cited in any of the following manners:

(a) On three or more separate occasions for final, nonappealable actual harm, but not immediate jeopardy deficiencies;

(b) On two or more separate occasions for final, nonappealable immediate jeopardy deficiencies; or

(c) on two separate occasions for final, nonappealable actual harm, but not immediate jeopardy deficiencies and on one occasion for a final, nonappealable immediate jeopardy deficiency.

(2) In applying the provisions of paragraphs (K)(1)(a) to (c) of this rule, the director shall not consider deficiencies or violations cited before the applicant or a principal participant acquired or began to own or operate the health care facility at which the deficiencies or violations were cited. The director may disregard deficiencies and violations cited after the health care facility was acquired or began to be operated by the applicant or a principal participant if the deficiencies or violations were attributable to circumstances that arose under the previous owner or operator and the applicant or principal participant has implemented measures to alleviate the circumstances. In the case of an application proposing development of a new health care facility by relocation of beds, the director shall not consider deficiencies or violations that were solely attributable to the physical plant of the existing health care facility from which the beds are being relocated.

~~(2)~~(3) The director also may deny the certificate of need if the applicant, owner, operator, or any principal participant has been the subject of a final determination of medicare or medicaid fraud or abuse.

(L) In determining which applications should receive preference in a comparative review process, the director shall consider, in conjunction with all other applicable criteria prescribed by this chapter, all of the following as weighted priorities. Applications that meet all applicable criteria for certificate of need approval and that receive the most points under this paragraph will be given preference. When applications that meet all applicable criteria for certificate of need approval and that are under a comparative review process for the same county receive an equal number of points under this paragraph, the director shall give preference to the application that demonstrates the greatest need for the reviewable activity.

(1) Whether the project, as described in the application, is or will be part of a continuing care retirement community (CCRC) that complies with paragraph (I)(3) of this rule upon completion of the reviewable activity. This criterion is weighted with four points for a CCRC with at least a four to one ratio of alternative beds to long-term care beds, three points with at least a three to

one ratio, two points with at least a two to one ratio and one point with at least a one to one ratio. No points will be given if the ratio is less than one to one.

(a) The alternative beds shall be available to the residents and potential residents of the long-term care facility.

(b) Appropriate agreements shall exist between the long-term care facility and the alternative facility for transfer of residents.

(c) The applicant shall certify that the capital expenditure for the proposed alternative facility will be obligated, within the meaning of paragraph (A)(1)(a) of rule 3701-12-18 of the Administrative Code, at the same time as the capital expenditure for the portion of the project involving the long-term care facility.

(d) The applicant shall certify that no application will be filed by any person for a certificate of need for conversion of the alternative beds to long-term care beds for at least two years after the proposed alternative beds are occupied by residents.

(e) The application shall contain a certification that if for any reason the alternatives to inpatient long-term care cannot be developed or provided, development of the portion of the project involving the long-term care facility will be discontinued and the director will be notified immediately.

(f) The application shall contain documentation of how the long-term care facility and the alternative beds proposed will be integrated into the existing and projected community system for caring for elderly and individuals with disabilities. This documentation shall include at least:

(i) A thorough inventory of existing and projected alternative beds to inpatient long-term care within the county;

(ii) A description of the planning process leading to selection of the alternative beds proposed in the application, including discussions with appropriate community groups such as local aging agencies regarding the community's needs for alternative services; and

(iii) An analysis of the need in the community for the proposed alternative beds, taking into account the needs of the target

population, the existing and projected alternative services and beds in the community, the ability of the target population to assume the cost for an alternative bed, and the expected effect of the alternative beds on utilization of long-term care facilities. The application also shall contain a demonstration of the economic viability of the proposed alternative beds.

(2) Whether the beds will serve a medically underserved population such as low-income individuals, individuals with disabilities, or individuals who are members of racial or ethnic minority groups.

(a) If the project in which the beds will be included will serve low-income individuals or individuals who are members of racial or ethnic minority groups, this criterion is weighted with one point for each medically underserved population to be served by the project that is documented as being greater than or equal to twenty-five per cent of the population of the defined service area.

(b) If the project in which the beds will be included will primarily serve individuals with special health care needs such as traumatic or acquired brain injury, cerebral palsy, spinal cord injury or disability, multiple sclerosis, acquired immune deficiency syndrome or other similar conditions. This criterion is weighted three points.

(3) Whether the project in which the beds will be included will provide alternatives to institutional care, such as adult day-care, home health care, respite or hospice care, mobile meals, residential care, independent living, or congregate living services. This criterion is weighted with two points.

(4) Whether the health care facility's owner or operator will participate in medicaid waiver programs for alternatives to institutional care. This criterion is weighted with two points.

(5) Whether the project in which the beds will be included will reduce alternatives to institutional care by converting residential care beds or other alternative care beds to long-term care beds. This criterion is weighted with negative two points.

(6) Whether the facility in which the beds will be placed has positive resident and family satisfaction surveys. This criterion is weighted with one point.

(7) Whether the facility in which the beds will be placed has fewer than fifty

long-term care beds. This criterion is weighted with one point.

(8) Whether the health care facility in which the beds will be placed is located within the service area of a hospital and is or will be designed to accept patients for rehabilitation after an in-patient hospital stay. This criterion is weighted with two points.

(9) Whether the health care facility in which the beds will be placed is or proposes to become a nurse aide training and testing site. This criterion is weighted with one point.

(10) The rating, under the centers for medicare and medicaid services' five star nursing home quality rating system, of the health care facility in which the beds will be placed. This criterion is weighted with one point for a four star rating and two points for a five star rating at the time the application is declared complete.

(M) For applications made under the first comparative review process or under the first phase of a four year comparative review process, the director shall:

(1) Limit the number of beds approved for a county to no more than the number of beds determined to be needed in the receiving county;

(2) Maintain, after the relocation, the number of beds in the source facility's service area at least equal to the state bed need rate. For purposes of this paragraph, a facility's service area shall be either of the following:

(a) The census tract in which the facility is located, if the facility is located in an area designated by the United States secretary of health and human services as a health professional shortage area under the "Public Health Service Act," 88 Stat. 682 (1944), 42 U.S.C. 254 (e), as amended;

(b) The area that is within a fifteen mile radius of the facility's location, if the facility is not located in a health professional shortage area; and

(3) Require the operator of the health care facility from which beds were relocated to reduce the number of beds operated in the facility by a number of beds equal to at least ten per cent of the number of beds relocated and to surrender the operating rights to those beds to the director by de-licensing if the beds are licensed, de-registering if the beds are registered, and de-certifying if the beds are certified. In calculating the number of beds to be surrendered to the director, the number of beds shall be rounded to the nearest whole number.

This reduction shall be completed not later than the completion date of the project for which the beds were relocated.

(N) For applications made under the second phase of a four year comparative review process, the director shall:

(1) Limit the number of beds approved for a county to no more than the remaining bed need published for a county;

(2) Limit the number of beds approved for re-distribution to no more than the number of beds surrendered pursuant to paragraph (M)(4) of this rule from the first phase of the four year comparative review process at the time the last notice of completeness is mailed under paragraph (K) of rule 3701-12-08 of the Administrative Code for applications filed under this phase of the comparative review process; and

(3) Not re-distribute under a future comparative review process, any surrendered beds that were not re-distributed during the second phase of a four year comparative review process.

(O) When a certificate of need application is approved during the first phase of a four year review process, on completion of the project under which the beds are relocated, the operator shall cease to operate in the health care facility from which the beds were relocated, the number of beds that were relocated and, if those beds cannot be or are not transferred to the facility approved to receive the beds, the operating rights to those beds shall surrendered to the director by de-licensing if the beds are licensed, de-registering if the beds are registered, and de-certifying if the beds are certified.

(P) For applications that propose the inter-county relocation of beds or the re-distribution of surrendered beds pursuant to paragraph (M)(4) of this rule, the director shall consider existing community resources within the service area that are serving elderly or individuals with disabilities.

(Q) For applications that propose an increase in beds that is attributable to a replacement or relocation of existing beds from an existing healthcare facility within the same county, the director shall authorize no additional beds beyond those being replaced or relocated.

(R) If an application for a certificate of need to conduct a reviewable activity relating to a long-term care facility that is not yet existing and that proposes to reduce or eliminate any alternatives to inpatient long-term care that were included in a

previous, approved certificate of need application, the director shall review the application under all applicable criteria established by this rule and by other rules of this chapter as if the earlier certificate had not been granted.

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Certification

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Date

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