(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; emerg. cr. (1) (c), eff. 1-1-87; emerg. cr. (1) (c), am. (9), eff. 5-31-87; cr. (1) (c), (7) (c) and (9) (b), am. (7) (a), renum. (9) to be (9) (a) and am., Register, October, 1987, No. 382, eff. 11-1-87.

HSS 122.07 Review criteria and selection process. (1) 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 and FDDs, that C is less than or equal to 1.4 (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 and FDDs, that C_e is less than

$$\frac{1.4\ (S)\ (F)}{35}$$

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

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

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 construction.

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 com-

pared, 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. HSS 132 or 134;

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.

(lm) REVIEW CRITERIA FOR CONVERSION OF A NURSING HOME TO AN FDD. The department shall use the criteria in sub. (1) and the additional criteria in this subsection in its review of all applications for conversion of a nursing home to an FDD under s. HSS 122.02 (2) (a) and (c). The department shall solicit the comments of county departments organized under s. 46.23, 51.42, or 51.437, Stats., on all of these applications. The department shall not approve an application subject to this subsection unless the applicant has demonstrated that:

(a) The proposed per diem rates for the FDD are consistent with those of similar facilities for developmentally disabled persons;

(b) The applicant has experience in providing active treatment as defined in 42 CFR 435.1099 and the department has approved the applicant's program statement under s. HSS 132.51 (3);

(c) Conversion of some beds within a non-FDD nursing home to FDD beds will result in a physically separate unit of the facility, which may be a ward, contiguous wards, a wing, a floor or a building, and which is separately staffed;

(d) Staff will be efficiently deployed in the FDD part of the facility and in the nursing home part of the facility, as well as in the facility as a whole;

(e) The FDD will have a minimum of 16 beds for developmentally disabled persons; and

(f) 1. A number of developmentally disabled residents sufficient to fill the requested beds currently reside in the facility and require active treatment; and

2. If the applicant proposes more beds than it has residents under par. (f), that county departments organized under s. 46.23, 52.42 or 51.437, Stats., identify persons who need placement in an FDD and give assurances that these persons will be placed in that facility.

(2) RANKING AND SELECTION PROCESS. (a) Applications for new or redistributed 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 composite 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. The composite per diem rate shall be calculated as follows:

a. Multiply the proposed skilled nursing facility per diem rates, exclusive of supplements, for each payment source by the percentage of projected skilled nursing facility patient days by payment source; and

b. Add all the products of the multiplication in subpar. a to obtain the composite per diem rate;

2. The department shall review the applicant's methodology for calculation of the proposed rates for consistency with current reimbursement practices and reasonableness. An applicant whose rates are found to be inconsistent or unreasonable will be removed from the selection process;

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

4. 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; and

5. If the composite per diem rate for 2 or more of the applicants undergoing concurrent review is equal, the department shall approve or deny those projects as follows:

a. If the total number of beds proposed by all applicants undergoing concurrent review is less than the total number of beds available, each of the projects shall be approved; and

b. If the total number of beds proposed by all applicants undergoing concurrent review is greater than the number of beds available, applications shall be ranked on the basis of per bed cost as calculated in sub. (1) (c), beginning with the lowest and ending with the highest. The department shall then approve projects in order of this ranking until all beds available are distributed.

(am) Applications under s. HSS 122.02 (2) (a) and (c) which meet all of the criteria in subs. (1) and (1m) shall be subject to the following selection process:

1. If after removing from consideration all applications which fail to meet one or more review criteria, there remain more applications than can be approved for the beds available under s. HSS 122.04 (1) (b) 2 a, the department shall rank the remaining applications according to how each meets each applicable review criterion under subs. (1) and (1m), assigning the lowest number to the application which best meets each criterion.

2. The department shall approve applications in order beginning with the lowest score, until all available beds are allocated. If there is a tie between applications for the last available approval, the department shall rank the applications according to their scores on review criteria under sub. (1m) (b).

(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; emerg. cr. (1m) and (2) (am), eff. 1-1-87; am. (2) (a) (intro.) and 1., cr. (2) (a) 5., Register, January, 1987, No. 373, eff. 2-1-87; emerg. cr. (1m) and (2) (am), eff. 5-31-87; cr. (1m) and (2) (am), Register, October, 1987, No. 382, eff. 11-1-87; emerg. cr. (1r), eff. 10-1-88; emerg. am. (1) (c) 1. and 2. eff. 3-16-90; am. (1) (c) 1. and 2., Register, September, 1990, No. 417, eff. 10-1-90; correction in (1) (g) 1. made under s. 13.93 (2m) (b) 7., Stats., Register, September, 1990, No. 417.

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