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Representatives Newcomb, Lehner

Cosponsors: Representatives Harwood, Derickson, Domenick, Grossman, Garland, Hagan, Evans, Snitchler, Phillips, Williams, B., Dyer, Fende, Wachtmann, Ruhl, Hackett, Letson, Stebelton, Harris, Bulp, Hottinger, Stautberg, Pillich, Murray, Driehaus, Brown, McClain, Weddington, Mallory, Goyal, Baker, Blessing, Dolan, Yuko, Okey, Foley, Adams, R., Amstutz, Bacon, Balderson, Batchelder, Beck, Belcher, Boose, Boyd, Burke, Carney, Celeste, Chandler, Combs, Daniels, DeBose, DeGeeter, Gardner, Gerberry, Goodwin, Hall, Heard, Hite, Koziura, Luckie, Lundy, Maag, Martin, Mecklenborg, Moran, Morgan, Oelslager, Otterman, Patten, Pryor, Reece, Sayre, Sears, Skindell, Slesnick, Stewart, Szollosi, Uecker, Walter, Winburn, Zehringer

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A B I L L

To amend sections 173.401, 173.501, 3702.51, 3702.59, 1
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 2
5111.686, 5111.688, 5111.874, 5111.875, and 3
5111.894; to amend, for the purpose of adopting a 4
new section number as indicated in parentheses, 5
section 5111.688 (5111.689); and to enact new 6
section 5111.688 and section 173.404 of the 7
Revised Code; and to amend Section 209.20 of Am. 8
Sub. H.B. 1 of the 128th General Assembly to 9
revise the waiting list provisions of the 10
PASSPORT, PACE, and Assisted Living programs, to 11
revise the law governing the collection of 12

long-term care facilities' Medicaid debts, and to 13
revise the law governing the reasons for denying a 14
Certificate of Need application. 15

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

Section 1. That sections 173.401, 173.501, 3702.51, 3702.59, 16
5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 17
5111.688, 5111.874, 5111.875, and 5111.894 be amended; section 18
5111.688 (5111.689) be amended for the purpose of adopting a new 19
section number as indicated in parentheses; and new section 20
5111.688 and section 173.404 of the Revised Code be enacted to 21
read as follows: 22

Sec. 173.401. (A) As used in this section: 23

"Area agency on aging" has the same meaning as in section 24
173.14 of the Revised Code. 25

"Long-term care consultation program" means the program the 26
department of aging is required to develop under section 173.42 of 27
the Revised Code. 28

"Long-term care consultation program administrator" or 29
"administrator" means the department of aging or, if the 30
department contracts with an area agency on aging or other entity 31
to administer the long-term care consultation program for a 32
particular area, that agency or entity. 33

"Nursing facility" has the same meaning as in section 5111.20 34
of the Revised Code. 35

"PASSPORT waiver" means the federal medicaid waiver granted 36
by the United States secretary of health and human services that 37
authorizes the PASSPORT program. 38

(B) ~~The director of job and family services shall submit to~~ 39

~~the United States secretary of health and human services an~~ 40
~~amendment to the PASSPORT waiver that authorizes additional~~ 41
~~enrollments in the PASSPORT program pursuant to this section.~~ 42
~~Beginning with the month following the month in which the United~~ 43
~~States secretary approves the amendment and each~~ The department 44
shall establish a home first component of the PASSPORT program 45
under which eligible individuals may be enrolled in the PASSPORT 46
program in accordance with this section. An individual is eligible 47
for the PASSPORT program's home first component if all of the 48
following apply: 49

(1) The individual is eligible for the PASSPORT program. 50

(2) The individual is on the unified waiting list established 51
under section 173.404 of the Revised Code. 52

(3) At least one of the following applies: 53

(a) The individual has been admitted to a nursing facility. 54

(b) A physician has determined and documented in writing that 55
the individual has a medical condition that, unless the individual 56
is enrolled in home and community-based services such as the 57
PASSPORT program, will require the individual to be admitted to a 58
nursing facility within thirty days of the physician's 59
determination. 60

(c) The individual has been hospitalized and a physician has 61
determined and documented in writing that, unless the individual 62
is enrolled in home and community-based services such as the 63
PASSPORT program, the individual is to be transported directly 64
from the hospital to a nursing facility and admitted. 65

(d) Both of the following apply: 66

(i) The individual is the subject of a report made under 67
section 5101.61 of the Revised Code regarding abuse, neglect, or 68
exploitation or such a report referred to a county department of 69

job and family services under section 5126.31 of the Revised Code 70
or has made a request to a county department for protective 71
services as defined in section 5101.60 of the Revised Code. 72

(ii) A county department of job and family services and an 73
area agency on aging have jointly documented in writing that, 74
unless the individual is enrolled in home and community-based 75
services such as the PASSPORT program, the individual should be 76
admitted to a nursing facility. 77

(C) Each month thereafter, each area agency on aging shall 78
~~determine whether~~ identify individuals ~~who reside~~ residing in the 79
area that the area agency ~~on aging serves and who~~ are ~~on a waiting~~ 80
~~list~~ eligible for the home first component of the PASSPORT program 81
~~have been admitted to a nursing facility.~~ If When an area agency 82
on aging ~~determines that~~ identifies such an individual ~~has been~~ 83
~~admitted to a nursing facility,~~ the agency shall notify the 84
long-term care consultation program administrator serving the area 85
in which the individual resides ~~about the determination.~~ The 86
administrator shall determine whether the PASSPORT program is 87
appropriate for the individual and whether the individual would 88
rather participate in the PASSPORT program than continue ~~residing~~ 89
or begin to reside in ~~the~~ a nursing facility. If the administrator 90
determines that the PASSPORT program is appropriate for the 91
individual and the individual would rather participate in the 92
PASSPORT program than continue ~~residing~~ or begin to reside in ~~the~~ 93
a nursing facility, the administrator shall so notify the 94
department of aging. On receipt of the notice from the 95
administrator, the department ~~of aging~~ shall approve the 96
individual's enrollment in the PASSPORT program regardless of the 97
~~PASSPORT program's~~ unified waiting list ~~and even though the~~ 98
~~enrollment causes enrollment in the program to exceed the limit~~ 99
~~that would otherwise apply~~ established under section 173.404 of 100
the Revised Code, unless the enrollment would cause the PASSPORT 101

program to exceed any limit on the number of individuals who may 102
be enrolled in the program as set by the United States secretary 103
of health and human services in the PASSPORT waiver. 104

(D) Each quarter, the department of aging shall certify to 105
the director of budget and management the estimated increase in 106
costs of the PASSPORT program resulting from enrollment of 107
individuals in the PASSPORT program pursuant to this section. 108

Sec. 173.404. (A) As used in this section: 109

(1) "Department of aging-administered medicaid waiver 110
component" means each of the following: 111

(a) The PASSPORT program created under section 173.40 of the 112
Revised Code; 113

(b) The choices program created under section 173.403 of the 114
Revised Code; 115

(c) The assisted living program created under section 5111.89 116
of the Revised Code. 117

(2) "PACE program" means the component of the medicaid 118
program the department of aging administers pursuant to section 119
173.50 of the Revised Code. 120

(B) The department of aging shall establish a unified waiting 121
list for department of aging-administered medicaid waiver 122
components and the PACE program. Only individuals eligible for a 123
department of aging-administered medicaid waiver component or the 124
PACE program may be placed on the unified waiting list. 125

Sec. 173.501. (A) As used in this section: 126

"Nursing facility" has the same meaning as in section 5111.20 127
of the Revised Code. 128

"PACE provider" has the same meaning as in 42 U.S.C. 129

1396u-4(a)(3).	130
<u>(B) The department of aging shall establish a home first</u>	131
<u>component of the PACE program under which eligible individuals may</u>	132
<u>be enrolled in the PACE program in accordance with this section.</u>	133
<u>An individual is eligible for the PACE program's home first</u>	134
<u>component if all of the following apply:</u>	135
<u>(1) The individual is eligible for the PACE program.</u>	136
<u>(2) The individual is on the unified waiting list established</u>	137
<u>under section 173.404 of the Revised Code.</u>	138
<u>(3) At least one of the following applies:</u>	139
<u>(a) The individual has been admitted to a nursing facility.</u>	140
<u>(b) A physician has determined and documented in writing that</u>	141
<u>the individual has a medical condition that, unless the individual</u>	142
<u>is enrolled in home and community-based services such as the PACE</u>	143
<u>program, will require the individual to be admitted to a nursing</u>	144
<u>facility within thirty days of the physician's determination.</u>	145
<u>(c) The individual has been hospitalized and a physician has</u>	146
<u>determined and documented in writing that, unless the individual</u>	147
<u>is enrolled in home and community-based services such as the PACE</u>	148
<u>program, the individual is to be transported directly from the</u>	149
<u>hospital to a nursing facility and admitted.</u>	150
<u>(d) Both of the following apply:</u>	151
<u>(i) The individual is the subject of a report made under</u>	152
<u>section 5101.61 of the Revised Code regarding abuse, neglect, or</u>	153
<u>exploitation or such a report referred to a county department of</u>	154
<u>job and family services under section 5126.31 of the Revised Code</u>	155
<u>or has made a request to a county department for protective</u>	156
<u>services as defined in section 5101.60 of the Revised Code.</u>	157
<u>(ii) A county department of job and family services and an</u>	158
<u>area agency on aging have jointly documented in writing that,</u>	159

unless the individual is enrolled in home and community-based 160
services such as the PACE program, the individual should be 161
admitted to a nursing facility. 162

(C) Each month, the department of aging shall ~~determine~~ 163
~~whether~~ identify individuals who are ~~on a waiting list~~ eligible 164
for the home first component of the PACE program ~~have been~~ 165
~~admitted to a nursing facility.~~ If When the department ~~determines~~ 166
~~that~~ identifies such an individual ~~has been admitted to a nursing~~ 167
~~facility,~~ the department shall notify the PACE provider serving 168
the area in which the individual resides ~~about the determination.~~ 169
The PACE provider shall determine whether the PACE program is 170
appropriate for the individual and whether the individual would 171
rather participate in the PACE program than continue ~~residing or~~ 172
begin to reside in ~~the a~~ nursing facility. If the PACE provider 173
determines that the PACE program is appropriate for the individual 174
and the individual would rather participate in the PACE program 175
than continue ~~residing or~~ begin to reside in ~~the a~~ nursing 176
facility, the PACE provider shall so notify the department of 177
aging. On receipt of the notice from the PACE provider, the 178
department of aging shall approve the individual's enrollment in 179
the PACE program in accordance with priorities established in 180
rules adopted under section 173.50 of the Revised Code. ~~Each~~ 181

(D) Each quarter, the department of aging shall certify to 182
the director of budget and management the estimated increase in 183
costs of the PACE program resulting from enrollment of individuals 184
in the PACE program pursuant to this section. 185

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the 186
Revised Code: 187

(A) "Applicant" means any person that submits an application 188
for a certificate of need and who is designated in the application 189
as the applicant. 190

(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity.	191 192 193
(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity.	194 195 196
(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code.	197 198 199
(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service.	200 201
(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code.	202 203 204
(G) "Health care facility" means:	205
(1) A hospital registered under section 3701.07 of the Revised Code;	206 207
(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;	208 209 210
(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;	211 212 213 214
(4) A freestanding dialysis center;	215
(5) A freestanding inpatient rehabilitation facility;	216
(6) An ambulatory surgical facility;	217
(7) A freestanding cardiac catheterization facility;	218
(8) A freestanding birthing center;	219

(9) A freestanding or mobile diagnostic imaging center; 220

(10) A freestanding radiation therapy center. 221

A health care facility does not include the offices of 222
private physicians and dentists whether for individual or group 223
practice, residential facilities licensed under section 5123.19 of 224
the Revised Code, or an institution for the sick that is operated 225
exclusively for patients who use spiritual means for healing and 226
for whom the acceptance of medical care is inconsistent with their 227
religious beliefs, accredited by a national accrediting 228
organization, exempt from federal income taxation under section 229
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 230
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 231
care pursuant to the exemption in division (E) of section 4723.32 232
of the Revised Code from the licensing requirements of Chapter 233
4723. of the Revised Code. 234

(H) "Medical equipment" means a single unit of medical 235
equipment or a single system of components with related functions 236
that is used to provide health services. 237

(I) "Third-party payer" means a health insuring corporation 238
licensed under Chapter 1751. of the Revised Code, a health 239
maintenance organization as defined in division (K) of this 240
section, an insurance company that issues sickness and accident 241
insurance in conformity with Chapter 3923. of the Revised Code, a 242
state-financed health insurance program under Chapter 3701., 243
4123., or 5111. of the Revised Code, or any self-insurance plan. 244

(J) "Government unit" means the state and any county, 245
municipal corporation, township, or other political subdivision of 246
the state, or any department, division, board, or other agency of 247
the state or a political subdivision. 248

(K) "Health maintenance organization" means a public or 249
private organization organized under the law of any state that is 250

qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9. 251
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(L) "Existing health care facility" means either of the following: 253
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(1) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, is staffed and equipped to provide health care services, and is actively providing health services; 255
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(2) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or that has beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds and has provided services for at least three hundred sixty-five consecutive days within the twenty-four months immediately preceding the date a certificate of need application is filed with the director of health. 262
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(M) "State" means the state of Ohio, including, but not limited to, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards, offices, commissions, agencies, institutions, and other instrumentalities of the state of Ohio. "State" does not include political subdivisions. 273
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(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in 279
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geographic areas smaller than that of the state to which the	282
sovereign immunity of the state attaches.	283
(O) "Affected person" means:	284
(1) An applicant for a certificate of need, including an	285
applicant whose application was reviewed comparatively with the	286
application in question;	287
(2) The person that requested the reviewability ruling in	288
question;	289
(3) Any person that resides or regularly uses health care	290
facilities within the geographic area served or to be served by	291
the health care services that would be provided under the	292
certificate of need or reviewability ruling in question;	293
(4) Any health care facility that is located in the health	294
service area where the health care services would be provided	295
under the certificate of need or reviewability ruling in question;	296
(5) Third-party payers that reimburse health care facilities	297
for services in the health service area where the health care	298
services would be provided under the certificate of need or	299
reviewability ruling in question;	300
(6) Any other person who testified at a public hearing held	301
under division (B) of section 3702.52 of the Revised Code or	302
submitted written comments in the course of review of the	303
certificate of need application in question.	304
(P) "Osteopathic hospital" means a hospital registered under	305
section 3701.07 of the Revised Code that advocates osteopathic	306
principles and the practice and perpetuation of osteopathic	307
medicine by doing any of the following:	308
(1) Maintaining a department or service of osteopathic	309
medicine or a committee on the utilization of osteopathic	310
principles and methods, under the supervision of an osteopathic	311

physician;	312
(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;	313 314
(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.	315 316
(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.	317 318
(R) Except as provided in division (S) of this section, "reviewable activity" means any of the following activities:	319 320
(1) The establishment, development, or construction of a new long-term care facility;	321 322
(2) The replacement of an existing long-term care facility;	323
(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;	324 325 326 327
(4) Either of the following changes in long-term care bed capacity:	328 329
(a) An increase in bed capacity;	330
(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.	331 332 333 334
(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity 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;	335 336 337 338 339 340

(6) The expenditure of more than one hundred ten per cent of	341
the maximum expenditure specified in a certificate of need	342
concerning long-term care beds.	343
(S) "Reviewable activity" does not include any of the	344
following activities:	345
(1) Acquisition of computer hardware or software;	346
(2) Acquisition of a telephone system;	347
(3) Construction or acquisition of parking facilities;	348
(4) Correction of cited deficiencies that are in violation of	349
federal, state, or local fire, building, or safety laws and rules	350
and that constitute an imminent threat to public health or safety;	351
(5) Acquisition of an existing health care facility that does	352
not involve a change in the number of the beds, by service, or in	353
the number or type of health services;	354
(6) Correction of cited deficiencies identified by	355
accreditation surveys of the joint commission on accreditation of	356
healthcare organizations or of the American osteopathic	357
association;	358
(7) Acquisition of medical equipment to replace the same or	359
similar equipment for which a certificate of need has been issued	360
if the replaced equipment is removed from service;	361
(8) Mergers, consolidations, or other corporate	362
reorganizations of health care facilities that do not involve a	363
change in the number of beds, by service, or in the number or type	364
of health services;	365
(9) Construction, repair, or renovation of bathroom	366
facilities;	367
(10) Construction of laundry facilities, waste disposal	368
facilities, dietary department projects, heating and air	369
conditioning projects, administrative offices, and portions of	370

medical office buildings used exclusively for physician services; 371

(11) Acquisition of medical equipment to conduct research 372
required by the United States food and drug administration or 373
clinical trials sponsored by the national institute of health. Use 374
of medical equipment that was acquired without a certificate of 375
need under division (S)(11) of this section and for which 376
premarket approval has been granted by the United States food and 377
drug administration to provide services for which patients or 378
reimbursement entities will be charged shall be a reviewable 379
activity. 380

(12) Removal of asbestos from a health care facility. 381

Only that portion of a project that meets the requirements of 382
this division is not a reviewable activity. 383

(T) "Small rural hospital" means a hospital that is located 384
within a rural area, has fewer than one hundred beds, and to which 385
fewer than four thousand persons were admitted during the most 386
recent calendar year. 387

(U) "Children's hospital" means any of the following: 388

(1) A hospital registered under section 3701.07 of the 389
Revised Code that provides general pediatric medical and surgical 390
care, and in which at least seventy-five per cent of annual 391
inpatient discharges for the preceding two calendar years were 392
individuals less than eighteen years of age; 393

(2) A distinct portion of a hospital registered under section 394
3701.07 of the Revised Code that provides general pediatric 395
medical and surgical care, has a total of at least one hundred 396
fifty registered pediatric special care and pediatric acute care 397
beds, and in which at least seventy-five per cent of annual 398
inpatient discharges for the preceding two calendar years were 399
individuals less than eighteen years of age; 400

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (U)(1) of this section.

(V) "Long-term care facility" means any of the following:

(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act";

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds.

(W) "Long-term care bed" means a bed in a long-term care facility.

(X) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited maternity unit.

(Y)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.

(Z)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin no. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

(AA) "County nursing home" has the same meaning as in section 5155.31 of the Revised Code.

(BB) "Principal participant" means both of the following:

(1) A person who has an ownership or controlling interest of at least five per cent in an applicant, in a health care facility that is the subject of an application for a certificate of need, or in the owner or operator of the applicant or such a facility;

(2) An officer, director, trustee, or general partner of an applicant, of a health care facility that is the subject of an application for a certificate of need, or of the owner or operator of the applicant or such a facility.

(CC) "Actual harm but not immediate jeopardy deficiency" means a deficiency that, under 42 C.F.R. 488.404, either constitutes a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or represents widespread deficiencies resulting in actual harm that is not immediate jeopardy.

(DD) "Immediate jeopardy deficiency" means a deficiency that, under 42 C.F.R. 488.404, either constitutes a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or represents widespread deficiencies resulting in immediate jeopardy to resident health or safety.

Sec. 3702.59. (A) The director of health shall accept for

review certificate of need applications as provided in sections 461
3702.592, 3702.593, and 3702.594 of the Revised Code. 462

(B)(1) The director shall not approve an application for a 463
certificate of need for the addition of long-term care beds to an 464
existing health care facility or for the development of a new 465
health care facility if any of the following apply: 466

~~(1)(a)~~ (a) The existing health care facility in which the beds 467
are being placed has one or more waivers for life safety code 468
deficiencies, one or more state fire code violations, or one or 469
more state building code violations, and the project identified in 470
the application does not propose to correct all life safety code 471
deficiencies for which a waiver has been granted, all state fire 472
code violations, and all state building code violations at the 473
existing health care facility in which the beds are being placed; 474

~~(2)(b)~~ (b) During the sixty-month period preceding the filing of 475
the application, a notice of proposed license revocation was 476
issued under section 3721.03 of the Revised Code for the existing 477
health care facility in which the beds are being placed or a 478
nursing home owned or operated by the applicant or ~~the corporation~~ 479
~~or other business that operates or seeks to operate the health~~ 480
~~care facility in which the beds are being placed~~ a principal 481
participant. 482

~~(3)(c)~~ (c) During the period that precedes the filing of the 483
application and is encompassed by the three most recent standard 484
surveys of the existing health care facility in which the beds are 485
being placed, ~~the~~ any of the following occurred: 486

(i) The facility was cited on three or more separate 487
occasions for final, nonappealable actual harm but not immediate 488
jeopardy deficiencies ~~that, under 42 C.F.R. 488.404, either~~ 489
~~constitute a pattern of deficiencies resulting in actual harm that~~ 490
~~is not immediate jeopardy or are widespread deficiencies resulting~~ 491

~~in actual harm that is not immediate jeopardy.~~ 492

~~(4) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, the (ii) The facility was cited on two or more separate occasions for final, nonappealable immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in immediate jeopardy to resident health or safety or are widespread deficiencies resulting in immediate jeopardy to resident health or safety.~~ 493
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~~(5) During the period that precedes the filing of the application and is encompassed by the three most recent standard surveys of the existing health care facility in which the beds are being placed, more (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.~~ 502
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~~(d) More than two nursing homes owned or operated in this state by the applicant or ~~the person who operates the facility in which the beds are being placed~~ a principal participant or, if the applicant or ~~person~~ 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 ~~on~~ 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:~~ 509
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~~(i) On three or more separate occasions for final, nonappealable actual harm but not immediate jeopardy deficiencies that, under 42 C.F.R. 488.404, either constitute a pattern of deficiencies resulting in actual harm that is not immediate jeopardy or are widespread deficiencies resulting in actual harm~~ 519
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523

~~that is not immediate jeopardy.~~ 524

~~(6) During the period that precedes the filing of the 525
application and is encompassed by the three most recent standard 526
surveys of the existing health care facility in which the beds are 527
being placed, more than two nursing homes operated in this state 528
by the applicant or the person who operates the facility in which 529
the beds are being placed or, if the applicant or person operates 530
more than twenty nursing homes in this state, more than ten per 531
cent of those nursing homes, were each cited on;~~ 532

~~(ii) On two or more separate occasions for final, 533
nonappealable immediate jeopardy deficiencies that, under 42 534
C.F.R. 488.404, either constitute a pattern of deficiencies 535
resulting in immediate jeopardy to resident health or safety or 536
are widespread deficiencies resulting in immediate jeopardy to 537
resident health or safety;~~ 538

~~(iii) On two separate occasions for final, nonappealable 539
actual harm but not immediate jeopardy deficiencies and on one 540
occasion for a final, nonappealable immediate jeopardy deficiency. 541~~

~~(7) During the sixty month period preceding the filing of the 542
application, the applicant has violated this chapter on two or 543
more separate occasions.~~ 544

~~(2) In applying divisions (B)(1)(a) to (6)(d) of this 545
section, the director shall not consider deficiencies or 546
violations cited before the ~~current operator~~ applicant or a 547
principal participant acquired or began to own or operate the 548
health care facility at which the deficiencies or violations were 549
cited. The director may disregard deficiencies and violations 550
cited after the health care facility was acquired or began to be 551
operated by the ~~current operator~~ applicant or a principal 552
participant if the deficiencies or violations were attributable to 553
circumstances that arose under the previous owner or operator and 554~~

the ~~current operator~~ applicant or principal participant has 555
implemented measures to alleviate the circumstances. In the case 556
of an application proposing development of a new health care 557
facility by relocation of beds, the director shall not consider 558
deficiencies or violations that were solely attributable to the 559
physical plant of the existing health care facility from which the 560
beds are being relocated. 561

(C) The director also shall accept for review any application 562
for the conversion of infirmary beds to long-term care beds if the 563
infirmary meets all of the following conditions: 564

(1) Is operated exclusively by a religious order; 565

(2) Provides care exclusively to members of religious orders 566
who take vows of celibacy and live by virtue of their vows within 567
the orders as if related; 568

(3) Was providing care exclusively to members of such a 569
religious order on January 1, 1994. 570

At no time shall individuals other than those described in 571
division (C)(2) of this section be admitted to a facility to use 572
beds for which a certificate of need is approved under this 573
division. 574

Sec. 5111.65. As used in sections 5111.65 to ~~5111.688~~ 575
5111.689 of the Revised Code: 576

(A) "Affiliated operator" means an operator affiliated with 577
either of the following: 578

(1) The exiting operator for whom the affiliated operator is 579
to assume liability for the entire amount of the exiting 580
operator's debt under the medicaid program or the portion of the 581
debt that represents the franchise permit fee the exiting operator 582
owes; 583

(2) The entering operator involved in the change of operator 584

with the exiting operator specified in division (A)(1) of this 585
section. 586

(B) "Change of operator" means an entering operator becoming 587
the operator of a nursing facility or intermediate care facility 588
for the mentally retarded in the place of the exiting operator. 589

(1) Actions that constitute a change of operator include the 590
following: 591

(a) A change in an exiting operator's form of legal 592
organization, including the formation of a partnership or 593
corporation from a sole proprietorship; 594

(b) A transfer of all the exiting operator's ownership 595
interest in the operation of the facility to the entering 596
operator, regardless of whether ownership of any or all of the 597
real property or personal property associated with the facility is 598
also transferred; 599

(c) A lease of the facility to the entering operator or the 600
exiting operator's termination of the exiting operator's lease; 601

(d) If the exiting operator is a partnership, dissolution of 602
the partnership; 603

(e) If the exiting operator is a partnership, a change in 604
composition of the partnership unless both of the following apply: 605

(i) The change in composition does not cause the 606
partnership's dissolution under state law. 607

(ii) The partners agree that the change in composition does 608
not constitute a change in operator. 609

(f) If the operator is a corporation, dissolution of the 610
corporation, a merger of the corporation into another corporation 611
that is the survivor of the merger, or a consolidation of one or 612
more other corporations to form a new corporation. 613

(2) The following, alone, do not constitute a change of 614

operator: 615

(a) A contract for an entity to manage a nursing facility or 616
intermediate care facility for the mentally retarded as the 617
operator's agent, subject to the operator's approval of daily 618
operating and management decisions; 619

(b) A change of ownership, lease, or termination of a lease 620
of real property or personal property associated with a nursing 621
facility or intermediate care facility for the mentally retarded 622
if an entering operator does not become the operator in place of 623
an exiting operator; 624

(c) If the operator is a corporation, a change of one or more 625
members of the corporation's governing body or transfer of 626
ownership of one or more shares of the corporation's stock, if the 627
same corporation continues to be the operator. 628

~~(B)~~(C) "Effective date of a change of operator" means the day 629
the entering operator becomes the operator of the nursing facility 630
or intermediate care facility for the mentally retarded. 631

~~(C)~~(D) "Effective date of a facility closure" means the last 632
day that the last of the residents of the nursing facility or 633
intermediate care facility for the mentally retarded resides in 634
the facility. 635

~~(D)~~(E) "Effective date of a voluntary termination" means the 636
day the intermediate care facility for the mentally retarded 637
ceases to accept medicaid patients. 638

~~(E)~~(F) "Effective date of a voluntary withdrawal of 639
participation" means the day the nursing facility ceases to accept 640
new medicaid patients other than the individuals who reside in the 641
nursing facility on the day before the effective date of the 642
voluntary withdrawal of participation. 643

~~(F)~~(G) "Entering operator" means the person or government 644

entity that will become the operator of a nursing facility or 645
intermediate care facility for the mentally retarded when a change 646
of operator occurs. 647

~~(G)~~(H) "Exiting operator" means any of the following: 648

(1) An operator that will cease to be the operator of a 649
nursing facility or intermediate care facility for the mentally 650
retarded on the effective date of a change of operator; 651

(2) An operator that will cease to be the operator of a 652
nursing facility or intermediate care facility for the mentally 653
retarded on the effective date of a facility closure; 654

(3) An operator of an intermediate care facility for the 655
mentally retarded that is undergoing or has undergone a voluntary 656
termination; 657

(4) An operator of a nursing facility that is undergoing or 658
has undergone a voluntary withdrawal of participation. 659

~~(H)~~(I)(1) "Facility closure" means discontinuance of the use 660
of the building, or part of the building, that houses the facility 661
as a nursing facility or intermediate care facility for the 662
mentally retarded that results in the relocation of all of the 663
facility's residents. A facility closure occurs regardless of any 664
of the following: 665

(a) The operator completely or partially replacing the 666
facility by constructing a new facility or transferring the 667
facility's license to another facility; 668

(b) The facility's residents relocating to another of the 669
operator's facilities; 670

(c) Any action the department of health takes regarding the 671
facility's certification under Title XIX of the "Social Security 672
Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may 673
result in the transfer of part of the facility's survey findings 674

to another of the operator's facilities; 675

(d) Any action the department of health takes regarding the 676
facility's license under Chapter 3721. of the Revised Code; 677

(e) Any action the department of developmental disabilities 678
takes regarding the facility's license under section 5123.19 of 679
the Revised Code. 680

(2) A facility closure does not occur if all of the 681
facility's residents are relocated due to an emergency evacuation 682
and one or more of the residents return to a medicaid-certified 683
bed in the facility not later than thirty days after the 684
evacuation occurs. 685

~~(I)~~(J) "Fiscal year," "franchise permit fee," "intermediate 686
care facility for the mentally retarded," "nursing facility," 687
"operator," "owner," and "provider agreement" have the same 688
meanings as in section 5111.20 of the Revised Code. 689

~~(J)~~(K) "Voluntary termination" means an operator's voluntary 690
election to terminate the participation of an intermediate care 691
facility for the mentally retarded in the medicaid program but to 692
continue to provide service of the type provided by a residential 693
facility as defined in section 5123.19 of the Revised Code. 694

~~(K)~~(L) "Voluntary withdrawal of participation" means an 695
operator's voluntary election to terminate the participation of a 696
nursing facility in the medicaid program but to continue to 697
provide service of the type provided by a nursing facility. 698

Sec. 5111.651. Sections 5111.65 to ~~5111.688~~ 5111.689 of the 699
Revised Code do not apply to a nursing facility or intermediate 700
care facility for the mentally retarded that undergoes a facility 701
closure, voluntary termination, voluntary withdrawal of 702
participation, or change of operator on or before September 30, 703
2005, if the exiting operator provided written notice of the 704

facility closure, voluntary termination, voluntary withdrawal of 705
participation, or change of operator to the department of job and 706
family services on or before June 30, 2005. 707

Sec. 5111.68. (A) On receipt of a written notice under 708
section 5111.66 of the Revised Code of a facility closure, 709
voluntary termination, or voluntary withdrawal of participation or 710
a written notice under section 5111.67 of the Revised Code of a 711
change of operator, the department of job and family services 712
shall ~~determine~~ estimate the amount of any overpayments made under 713
the medicaid program to the exiting operator, including 714
overpayments the exiting operator disputes, and other actual and 715
potential debts the exiting operator owes or may owe to the 716
department and United States centers for medicare and medicaid 717
services under the medicaid program, including a franchise permit 718
fee. ~~In determining~~ 719

(B) In estimating the exiting operator's other actual and 720
potential debts to the department and the United States centers 721
for medicare and medicaid services under the medicaid program, the 722
department shall ~~include~~ use a debt estimation methodology the 723
director of job and family services shall establish in rules 724
adopted under section 5111.689 of the Revised Code. The 725
methodology shall provide for estimating all of the following that 726
the department determines ~~is~~ are applicable: 727

(1) Refunds due the department under section 5111.27 of the 728
Revised Code; 729

(2) Interest owed to the department and United States centers 730
for medicare and medicaid services; 731

(3) Final civil monetary and other penalties for which all 732
right of appeal has been exhausted; 733

(4) Money owed the department and United States centers for 734

medicare and medicaid services from any outstanding final fiscal 735
audit, including a final fiscal audit for the last fiscal year or 736
portion thereof in which the exiting operator participated in the 737
medicaid program; 738

(5) Other amounts the department determines are applicable. 739

~~(B) If the department is unable to determine the amount of 740
the overpayments and other debts for any period before the 741
effective date of the entering operator's provider agreement or 742
the effective date of the facility closure, voluntary termination, 743
or voluntary withdrawal of participation, the department shall 744
make a reasonable estimate of the overpayments and other debts for 745
the period. The department shall make the estimate using 746
information available to the department, including prior 747
determinations of overpayments and other debts. 748~~

(C) The department shall provide the exiting operator written 749
notice of the department's estimate under division (A) of this 750
section not later than thirty days after the department receives 751
the notice under section 5111.66 of the Revised Code of the 752
facility closure, voluntary termination, or voluntary withdrawal 753
of participation or the notice under section 5111.67 of the 754
Revised Code of the change of operator. The department's written 755
notice shall include the basis for the estimate. 756

Sec. 5111.681. (A) Except as provided in ~~division~~ divisions 757
(B) and (C) of this section, the department of job and family 758
services ~~shall~~ may withhold ~~the greater of the following~~ from 759
payment due an exiting operator under the medicaid program; 760

~~(1) The the total amount of any overpayments made under the 761
medicaid program to the exiting operator, including overpayments 762
the exiting operator disputes, and other actual and potential 763
debts, including any unpaid penalties, specified in the notice 764
provided under division (C) of section 5111.68 of the Revised Code 765~~

that the exiting operator owes or may owe to the department and 766
United States centers for medicare and medicaid services under the 767
medicaid program; 768

~~(2) An amount equal to the average amount of monthly payments~~ 769
~~to the exiting operator under the medicaid program for the~~ 770
~~twelve-month period immediately preceding the month that includes~~ 771
~~the last day the exiting operator's provider agreement is in~~ 772
~~effect or, in the case of a voluntary withdrawal of participation,~~ 773
~~the effective date of the voluntary withdrawal of participation.~~ 774

(B) The In the case of a change of operator and subject to 775
division (D) of this section, the following shall apply regarding 776
a withholding under division (A) of this section if the exiting 777
operator or entering operator or an affiliated operator executes a 778
successor liability agreement meeting the requirements of division 779
(E) of this section: 780

(1) If the exiting operator, entering operator, or affiliated 781
operator assumes liability for the total, actual amount of debt 782
the exiting operator owes the department and the United States 783
centers for medicare and medicaid services under the medicaid 784
program as determined under section 5111.685 of the Revised Code, 785
the department may choose shall not to make the withholding under 786
division (A) of this section if an entering operator does both of 787
the following; 788

~~(1) Enters into a nontransferable, unconditional, written~~ 789
~~agreement with the department to pay the department any debt the~~ 790
~~exiting operator owes the department under the medicaid program;~~ 791

~~(2) Provides the department a copy of the entering operator's~~ 792
~~balance sheet that assists the department in determining whether~~ 793
~~to make the withholding under division (A) of this section.~~ 794

(2) If the exiting operator, entering operator, or affiliated 795
operator assumes liability for only the portion of the amount 796

specified in division (B)(1) of this section that represents the 797
franchise permit fee the exiting operator owes, the department 798
shall withhold not more than the difference between the total 799
amount specified in the notice provided under division (C) of 800
section 5111.68 of the Revised Code and the amount for which the 801
exiting operator, entering operator, or affiliated operator 802
assumes liability. 803

(C) In the case of a voluntary termination, voluntary 804
withdrawal of participation, or facility closure and subject to 805
division (D) of this section, the following shall apply regarding 806
a withholding under division (A) of this section if the exiting 807
operator or an affiliated operator executes a successor liability 808
agreement meeting the requirements of division (E) of this 809
section: 810

(1) If the exiting operator or affiliated operator assumes 811
liability for the total, actual amount of debt the exiting 812
operator owes the department and the United States centers for 813
medicare and medicaid services under the medicaid program as 814
determined under section 5111.685 of the Revised Code, the 815
department shall not make the withholding. 816

(2) If the exiting operator or affiliated operator assumes 817
liability for only the portion of the amount specified in division 818
(C)(1) of this section that represents the franchise permit fee 819
the exiting operator owes, the department shall withhold not more 820
than the difference between the total amount specified in the 821
notice provided under division (C) of section 5111.68 of the 822
Revised Code and the amount for which the exiting operator or 823
affiliated operator assumes liability. 824

(D) For an exiting operator or affiliated operator to be 825
eligible to enter into a successor liability agreement under 826
division (B) or (C) of this section, both of the following must 827
apply: 828

(1) The exiting operator or affiliated operator must have one 829
or more valid provider agreements, other than the provider 830
agreement for the nursing facility or intermediate care facility 831
for the mentally retarded that is the subject of the voluntary 832
termination, voluntary withdrawal of participation, facility 833
closure, or change of operator; 834

(2) During the twelve-month period preceding the month in 835
which the department receives the notice of the voluntary 836
termination, voluntary withdrawal of participation, or facility 837
closure under section 5111.66 of the Revised Code or the notice of 838
the change of operator under section 5111.67 of the Revised Code, 839
the average monthly medicaid payment made to the exiting operator 840
or affiliated operator pursuant to the exiting operator's or 841
affiliated operator's one or more provider agreements, other than 842
the provider agreement for the nursing facility or intermediate 843
care facility for the mentally retarded that is the subject of the 844
voluntary termination, voluntary withdrawal of participation, 845
facility closure, or change of operator, must equal at least 846
ninety per cent of the sum of the following: 847

(a) The average monthly medicaid payment made to the exiting 848
operator pursuant to the exiting operator's provider agreement for 849
the nursing facility or intermediate care facility for the 850
mentally retarded that is the subject of the voluntary 851
termination, voluntary withdrawal of participation, facility 852
closure, or change of operator; 853

(b) Whichever of the following apply: 854

(i) If the exiting operator or affiliated operator has 855
assumed liability under one or more other successor liability 856
agreements, the total amount for which the exiting operator or 857
affiliated operator has assumed liability under the other 858
successor liability agreements; 859

(ii) If the exiting operator or affiliated operator has not assumed liability under any other successor liability agreements, zero. 860
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(E) A successor liability agreement executed under this section must comply with all of the following: 863
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(1) It must provide for the operator who executes the successor liability agreement to assume liability for either of the following as specified in the agreement: 865
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867

(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code; 868
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(b) The portion of the amount specified in division (E)(1)(a) of this section that represents the franchise permit fee the exiting operator owes. 872
873
874

(2) It may not require the operator who executes the successor liability agreement to furnish a surety bond. 875
876

(3) It must provide that the department, after determining under section 5111.685 of the Revised Code the actual amount of debt the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, may deduct the lesser of the following from medicaid payments made to the operator who executes the successor liability agreement: 877
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(a) The total, actual amount of debt the exiting operator owes the department and the United States centers for medicare and medicaid services under the medicaid program as determined under section 5111.685 of the Revised Code; 884
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(b) The amount for which the operator who executes the successor liability agreement assumes liability under the 888
889

agreement. 890

(4) It must provide that the deductions authorized by 891
division (E)(3) of this section are to be made for a number of 892
months, not to exceed six, agreed to by the operator who executes 893
the successor liability agreement and the department or, if the 894
operator who executes the successor liability agreement and 895
department cannot agree on a number of months that is less than 896
six, a greater number of months determined by the attorney general 897
pursuant to a claims collection process authorized by statute of 898
this state. 899

(5) It must provide that, if the attorney general determines 900
the number of months for which the deductions authorized by 901
division (E)(3) of this section are to be made, the operator who 902
executes the successor liability agreement shall pay, in addition 903
to the amount collected pursuant to the attorney general's claims 904
collection process, the part of the amount so collected that, if 905
not for division (G) of this section, would be required by section 906
109.081 of the Revised Code to be paid into the attorney general 907
claims fund. 908

(F) Execution of a successor liability agreement does not 909
waive an exiting operator's right to contest the amount specified 910
in the notice the department provides the exiting operator under 911
division (C) of section 5111.68 of the Revised Code. 912

(G) Notwithstanding section 109.081 of the Revised Code, the 913
entire amount that the attorney general, whether by employees or 914
agents of the attorney general or by special counsel appointed 915
pursuant to section 109.08 of the Revised Code, collects under a 916
successor liability agreement, other than the additional amount 917
the operator who executes the agreement is required by division 918
(E)(5) of this section to pay, shall be paid to the department of 919
job and family services for deposit into the appropriate fund. The 920
additional amount that the operator is required to pay shall be 921

paid into the state treasury to the credit of the attorney general 922
claims fund created under section 109.081 of the Revised Code. 923

Sec. 5111.685. The department of job and family services 924
shall determine the actual amount of debt an exiting operator owes 925
the department and the United States centers for medicare and 926
medicaid services under the medicaid program by completing all 927
final fiscal audits not already completed and performing all other 928
appropriate actions the department determines to be necessary. The 929
department shall issue ~~a~~ an initial debt summary report on this 930
matter not later than ~~ninety~~ sixty days after the date the exiting 931
operator files the properly completed cost report required by 932
section 5111.682 of the Revised Code with the department or, if 933
the department waives the cost report requirement for the exiting 934
operator, ~~ninety~~ sixty days after the date the department waives 935
the cost report requirement. ~~The report shall include the~~ 936
~~department's findings and the amount of debt the department~~ 937
~~determines the exiting operator owes the department and United~~ 938
~~States centers for medicare and medicaid services under the~~ 939
~~medicaid program. Only the parts of the report that are subject to~~ 940
~~an adjudication as specified in section 5111.30 of the Revised~~ 941
~~Code are subject to an adjudication conducted~~ The initial debt 942
summary report becomes the final debt summary report thirty-one 943
days after the department issues the initial debt summary report 944
unless the exiting operator, or an affiliated operator who 945
executes a successor liability agreement under section 5111.681 of 946
the Revised Code, requests a review before that date. 947

The exiting operator, and an affiliated operator who executes 948
a successor liability agreement under section 5111.681 of the 949
Revised Code, may request a review to contest any of the 950
department's findings included in the initial debt summary report. 951
The request for the review must be submitted to the department not 952
later than thirty days after the date the department issues the 953

initial debt summary report. The department shall conduct the 954
review on receipt of a timely request and issue a revised debt 955
summary report. If the department has withheld money from payment 956
due the exiting operator under division (A) of section 5111.681 of 957
the Revised Code, the department shall issue the revised debt 958
summary report not later than ninety days after the date the 959
department receives the timely request for the review unless the 960
department and exiting operator or affiliated operator agree to a 961
later date. The exiting operator or affiliated operator may submit 962
information to the department explaining what the operator 963
contests before and during the review, including documentation of 964
the amount of any debt the department owes the operator. The 965
exiting operator or affiliated operator may submit additional 966
information to the department not later than thirty days after the 967
department issues the revised debt summary report. The revised 968
debt summary report becomes the final debt summary report 969
thirty-one days after the department issues the revised debt 970
summary report unless the exiting operator or affiliated operator 971
timely submits additional information to the department. If the 972
exiting operator or affiliated operator timely submits additional 973
information to the department, the department shall consider the 974
additional information and issue a final debt summary report not 975
later than sixty days after the department issues the revised debt 976
summary report unless the department and exiting operator or 977
affiliated operator agree to a later date. 978

Each debt summary report the department issues under this 979
section shall include the department's findings and the amount of 980
debt the department determines the exiting operator owes the 981
department and United States centers for medicare and medicaid 982
services under the medicaid program. The department shall explain 983
its findings and determination in each debt summary report. 984

The exiting operator, and an affiliated operator who executes 985

a successor liability agreement under section 5111.681 of the 986
Revised Code, may request, in accordance with Chapter 119. of the 987
Revised Code, an adjudication regarding a finding in a final debt 988
summary report that pertains to an audit or alleged overpayment 989
made under the medicaid program to the exiting operator. The 990
adjudication shall be consolidated with any other uncompleted 991
adjudication that concerns a matter addressed in the final debt 992
summary report. 993

Sec. 5111.686. The department of job and family services 994
shall release the actual amount withheld under division (A) of 995
section 5111.681 of the Revised Code, less any amount the exiting 996
operator owes the department and United States centers for 997
medicare and medicaid services under the medicaid program, as 998
follows: 999

(A) ~~Ninety one days after the date the exiting operator files~~ 1000
~~a properly completed cost report required by section 5111.682 of~~ 1001
~~the Revised Code unless~~ Unless the department issues the initial 1002
debt summary report required by section 5111.685 of the Revised 1003
Code not later than ~~ninety~~ sixty days after the date the exiting 1004
operator files the properly completed cost report required by 1005
section 5111.682 of the Revised Code, sixty-one days after the 1006
date the exiting operator files the properly completed cost 1007
report; 1008

(B) ~~Not later than thirty days after the exiting operator~~ 1009
~~agrees to a final fiscal audit resulting from the report required~~ 1010
~~by section 5111.685 of the Revised Code if~~ If the department 1011
issues the initial debt summary report required by section 1012
5111.685 of the Revised Code not later than ~~ninety~~ sixty days 1013
after the date the exiting operator files a properly completed 1014
cost report required by section 5111.682 of the Revised Code, not 1015
later than the following: 1016

(1) Thirty days after the deadline for requesting an adjudication under section 5111.685 of the Revised Code regarding the final debt summary report if the exiting operator, and an affiliated operator who executes a successor liability agreement under section 5111.681 of the Revised Code, fail to request the adjudication on or before the deadline; 1017
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(2) Thirty days after the completion of an adjudication of the final debt summary report if the exiting operator, or an affiliated operator who executes a successor liability agreement under section 5111.681 of the Revised Code, requests the adjudication on or before the deadline for requesting the adjudication. 1023
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~~(C) Ninety one days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code unless~~ Unless the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ninety sixty days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code, sixty-one days after the date the department waives the cost report requirement; 1029
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~~(D) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section 5111.685 of the Revised Code if~~ If the department issues the initial debt summary report required by section 5111.685 of the Revised Code not later than ninety sixty days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code, not later than the following: 1037
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(1) Thirty days after the deadline for requesting an adjudication under section 5111.685 of the Revised Code regarding the final debt summary report if the exiting operator, and an affiliated operator who executes a successor liability agreement 1045
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under section 5111.681 of the Revised Code, fail to request the 1049
adjudication on or before the deadline; 1050

(2) Thirty days after the completion of an adjudication of 1051
the final debt summary report if the exiting operator, or an 1052
affiliated operator who executes a successor liability agreement 1053
under section 5111.681 of the Revised Code, requests the 1054
adjudication on or before the deadline for requesting the 1055
adjudication. 1056

Sec. 5111.688. (A) All amounts withheld under section 1057
5111.681 of the Revised Code from payment due an exiting operator 1058
under the medicaid program shall be deposited into the medicaid 1059
payment withholding fund created by the controlling board pursuant 1060
to section 131.35 of the Revised Code. Money in the fund shall be 1061
used as follows: 1062

(1) To pay an exiting operator when a withholding is released 1063
to the exiting operator under section 5111.686 or 5111.687 of the 1064
Revised Code; 1065

(2) To pay the department of job and family services and 1066
United States centers for medicare and medicaid services the 1067
amount an exiting operator owes the department and United States 1068
centers under the medicaid program. 1069

(B) Amounts paid from the medicaid payment withholding fund 1070
pursuant to division (A)(2) of this section shall be deposited 1071
into the appropriate department fund. 1072

Sec. ~~5111.688~~ 5111.689. The director of job and family 1073
services shall adopt rules under section 5111.02 of the Revised 1074
Code to implement sections 5111.65 to ~~5111.688~~ 5111.689 of the 1075
Revised Code, including rules applicable to an exiting operator 1076
that provides written notification under section 5111.66 of the 1077
Revised Code of a voluntary withdrawal of participation. Rules 1078

adopted under this section shall comply with section 1919(c)(2)(F) 1079
of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1080
1396r(c)(2)(F), regarding restrictions on transfers or discharges 1081
of nursing facility residents in the case of a voluntary 1082
withdrawal of participation. The rules may prescribe a medicaid 1083
reimbursement methodology and other procedures that are applicable 1084
after the effective date of a voluntary withdrawal of 1085
participation that differ from the reimbursement methodology and 1086
other procedures that would otherwise apply. 1087

Sec. 5111.874. (A) As used in sections 5111.874 to 5111.8710 1088
of the Revised Code: 1089

"Home and community-based services" has the same meaning as 1090
in section 5123.01 of the Revised Code. 1091

"ICF/MR services" means intermediate care facility for the 1092
mentally retarded services covered by the medicaid program that an 1093
intermediate care facility for the mentally retarded provides to a 1094
resident of the facility who is a medicaid recipient eligible for 1095
medicaid-covered intermediate care facility for the mentally 1096
retarded services. 1097

"Intermediate care facility for the mentally retarded" means 1098
an intermediate care facility for the mentally retarded that is 1099
certified as in compliance with applicable standards for the 1100
medicaid program by the director of health in accordance with 1101
Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 1102
U.S.C. 1396, as amended, and licensed as a residential facility 1103
under section 5123.19 of the Revised Code. 1104

"Residential facility" has the same meaning as in section 1105
5123.19 of the Revised Code. 1106

(B) For the purpose of increasing the number of slots 1107
available for home and community-based services and subject to 1108

sections 5111.877 and 5111.878 of the Revised Code, the operator 1109
of an intermediate care facility for the mentally retarded may 1110
convert all of the beds in the facility from providing ICF/MR 1111
services to providing home and community-based services if all of 1112
the following requirements are met: 1113

(1) The operator provides the directors of health, job and 1114
family services, and developmental disabilities at least ninety 1115
days' notice of the operator's intent to relinquish the facility's 1116
certification as an intermediate care facility for the mentally 1117
retarded and to begin providing home and community-based services. 1118

(2) The operator complies with the requirements of sections 1119
5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a 1120
voluntary termination as defined in section 5111.65 of the Revised 1121
Code if those requirements are applicable. 1122

(3) The operator notifies each of the facility's residents 1123
that the facility is to cease providing ICF/MR services and inform 1124
each resident that the resident may do either of the following: 1125

(a) Continue to receive ICF/MR services by transferring to 1126
another facility that is an intermediate care facility for the 1127
mentally retarded willing and able to accept the resident if the 1128
resident continues to qualify for ICF/MR services; 1129

(b) Begin to receive home and community-based services 1130
instead of ICF/MR services from any provider of home and 1131
community-based services that is willing and able to provide the 1132
services to the resident if the resident is eligible for the 1133
services and a slot for the services is available to the resident. 1134

(4) The operator meets the requirements for providing home 1135
and community-based services, including the following: 1136

(a) Such requirements applicable to a residential facility if 1137
the operator maintains the facility's license as a residential 1138
facility; 1139

(b) Such requirements applicable to a facility that is not 1140
licensed as a residential facility if the operator surrenders the 1141
facility's residential facility license under section 5123.19 of 1142
the Revised Code. 1143

(5) The director of developmental disabilities approves the 1144
conversion. 1145

(C) The notice to the director of developmental disabilities 1146
under division (B)(1) of this section shall specify whether the 1147
operator wishes to surrender the facility's license as a 1148
residential facility under section 5123.19 of the Revised Code. 1149

(D) If the director of developmental disabilities approves a 1150
conversion under division (B) of this section, the director of 1151
health shall terminate the certification of the intermediate care 1152
facility for the mentally retarded to be converted. The director 1153
of health shall notify the director of job and family services of 1154
the termination. On receipt of the director of health's notice, 1155
the director of job and family services shall terminate the 1156
operator's medicaid provider agreement that authorizes the 1157
operator to provide ICF/MR services at the facility. The operator 1158
is not entitled to notice or a hearing under Chapter 119. of the 1159
Revised Code before the director of job and family services 1160
terminates the medicaid provider agreement. 1161

Sec. 5111.875. (A) For the purpose of increasing the number 1162
of slots available for home and community-based services and 1163
subject to sections 5111.877 and 5111.878 of the Revised Code, a 1164
person who acquires, through a request for proposals issued by the 1165
director of developmental disabilities, a residential facility 1166
that is an intermediate care facility for the mentally retarded 1167
and for which the license as a residential facility was previously 1168
surrendered or revoked may convert some or all of the facility's 1169
beds from providing ICF/MR services to providing home and 1170

community-based services if all of the following requirements are met:

(1) The person provides the directors of health, job and family services, and developmental disabilities at least ninety days' notice of the person's intent to make the conversion.

(2) The person complies with the requirements of sections 5111.65 to ~~5111.688~~ 5111.689 of the Revised Code regarding a voluntary termination as defined in section 5111.65 of the Revised Code if those requirements are applicable.

(3) If the person intends to convert all of the facility's beds, the person notifies each of the facility's residents that the facility is to cease providing ICF/MR services and informs each resident that the resident may do either of the following:

(a) Continue to receive ICF/MR services by transferring to another facility that is an intermediate care facility for the mentally retarded willing and able to accept the resident if the resident continues to qualify for ICF/MR services;

(b) Begin to receive home and community-based services instead of ICF/MR services from any provider of home and community-based services that is willing and able to provide the services to the resident if the resident is eligible for the services and a slot for the services is available to the resident.

(4) If the person intends to convert some but not all of the facility's beds, the person notifies each of the facility's residents that the facility is to convert some of its beds from providing ICF/MR services to providing home and community-based services and inform each resident that the resident may do either of the following:

(a) Continue to receive ICF/MR services from any provider of ICF/MR services that is willing and able to provide the services

to the resident if the resident continues to qualify for ICF/MR services; 1201
1202

(b) Begin to receive home and community-based services 1203
instead of ICF/MR services from any provider of home and 1204
community-based services that is willing and able to provide the 1205
services to the resident if the resident is eligible for the 1206
services and a slot for the services is available to the resident. 1207

(5) The person meets the requirements for providing home and 1208
community-based services at a residential facility. 1209

(B) The notice provided to the directors under division 1210
(A)(1) of this section shall specify whether some or all of the 1211
facility's beds are to be converted. If some but not all of the 1212
beds are to be converted, the notice shall specify how many of the 1213
facility's beds are to be converted and how many of the beds are 1214
to continue to provide ICF/MR services. 1215

(C) On receipt of a notice under division (A)(1) of this 1216
section, the director of health shall do the following: 1217

(1) Terminate the certification of the intermediate care 1218
facility for the mentally retarded if the notice specifies that 1219
all of the facility's beds are to be converted; 1220

(2) Reduce the facility's certified capacity by the number of 1221
beds being converted if the notice specifies that some but not all 1222
of the beds are to be converted. 1223

(D) The director of health shall notify the director of job 1224
and family services of the termination or reduction under division 1225
(C) of this section. On receipt of the director of health's 1226
notice, the director of job and family services shall do the 1227
following: 1228

(1) Terminate the person's medicaid provider agreement that 1229
authorizes the person to provide ICF/MR services at the facility 1230

if the facility's certification was terminated; 1231

(2) Amend the person's medicaid provider agreement to reflect 1232
the facility's reduced certified capacity if the facility's 1233
certified capacity is reduced. 1234

The person is not entitled to notice or a hearing under 1235
Chapter 119. of the Revised Code before the director of job and 1236
family services terminates or amends the medicaid provider 1237
agreement. 1238

~~Sec. 5111.894. The state administrative agency may establish 1239
one or more waiting lists for the assisted living program. Only 1240
individuals eligible for the medicaid program may be placed on a 1241
waiting list. (A) The state administrative agency shall establish 1242
a home first component of the assisted living program under which 1243
eligible individuals may be enrolled in the assisted living 1244
program in accordance with this section. An individual is eligible 1245
for the assisted living program's home first component if all of 1246
the following apply: 1247~~

(1) The individual is eligible for the assisted living 1248
program. 1249

(2) The individual is on the unified waiting list established 1250
under section 173.404 of the Revised Code. 1251

(3) At least one of the following applies: 1252

(a) The individual has been admitted to a nursing facility. 1253

(b) A physician has determined and documented in writing that 1254
the individual has a medical condition that, unless the individual 1255
is enrolled in home and community-based services such as the 1256
assisted living program, will require the individual to be 1257
admitted to a nursing facility within thirty days of the 1258
physician's determination. 1259

(c) The individual has been hospitalized and a physician has 1260

determined and documented in writing that, unless the individual 1261
is enrolled in home and community-based services such as the 1262
assisted living program, the individual is to be transported 1263
directly from the hospital to a nursing facility admitted. 1264

(d) Both of the following apply: 1265

(i) The individual is the subject of a report made under 1266
section 5101.61 of the Revised Code regarding abuse, neglect, or 1267
exploitation or such a report referred to a county department of 1268
job and family services under section 5126.31 of the Revised Code 1269
or has made a request to a county department for protective 1270
services as defined in section 5101.60 of the Revised Code. 1271

(ii) A county department of job and family services and an 1272
area agency on aging have jointly documented in writing that, 1273
unless the individual is enrolled in home and community-based 1274
services such as the assisted living program, the individual 1275
should be admitted to a nursing facility. 1276

(e) The individual resided in a residential care facility for 1277
at least six months immediately before applying for the assisted 1278
living program and is at risk of imminent admission to a nursing 1279
facility because the costs of residing in the residential care 1280
facility have depleted the individual's resources such that the 1281
individual is unable to continue to afford the cost of residing in 1282
the residential care facility. 1283

(B) Each month, each area agency on aging shall determine 1284
whether any individual who resides identify individuals residing 1285
in the area that the area agency on aging serves and is on a 1286
waiting list who are eligible for the home first component of the 1287
assisted living program has been admitted to a nursing facility. 1288
If When an area agency on aging determines that identifies such an 1289
individual has been admitted to a nursing facility and determines 1290
that there is a vacancy in a residential care facility 1291

participating in the assisted living program that is acceptable to 1292
the individual, the agency shall notify the long-term care 1293
consultation program administrator serving the area in which the 1294
individual resides ~~about the determination~~. The administrator 1295
shall determine whether the assisted living program is appropriate 1296
for the individual and whether the individual would rather 1297
participate in the assisted living program than continue ~~residing~~ 1298
or begin to reside in ~~the~~ a nursing facility. If the administrator 1299
determines that the assisted living program is appropriate for the 1300
individual and the individual would rather participate in the 1301
assisted living program than continue ~~residing~~ or begin to reside 1302
in ~~the~~ a nursing facility, the administrator shall so notify the 1303
state administrative ~~agency~~. 1304

~~On~~ agency. ~~On~~ receipt of the notice from the administrator, 1305
the state administrative agency shall approve the individual's 1306
enrollment in the assisted living program regardless of ~~any~~ the 1307
unified waiting list ~~for the assisted living program~~ established 1308
under section 173.404 of the Revised Code, unless the enrollment 1309
would cause the assisted living program to exceed any limit on the 1310
number of individuals who may participate in the program as set by 1311
the United States secretary of health and human services when the 1312
medicaid waiver authorizing the program is approved. ~~Each~~ 1313

(C) Each quarter, the state administrative agency shall 1314
certify to the director of budget and management the estimated 1315
increase in costs of the assisted living program resulting from 1316
enrollment of individuals in the assisted living program pursuant 1317
to this section. 1318

Section 2. That existing sections 173.401, 173.501, 3702.51, 1319
3702.59, 5111.65, 5111.651, 5111.68, 5111.681, 5111.685, 5111.686, 1320
5111.688, 5111.874, 5111.875, and 5111.894 of the Revised Code are 1321
hereby repealed. 1322

Section 3. That Section 209.20 of Am. Sub. H.B. 1 of the 128th General Assembly be amended to read as follows:

Sec. 209.20. LONG-TERM CARE

Pursuant to an interagency agreement, the Department of Job and Family Services shall designate the Department of Aging to perform assessments under section 5111.204 of the Revised Code. The Department of Aging shall provide long-term care consultations under section 173.42 of the Revised Code to assist individuals in planning for their long-term health care needs. The foregoing appropriation items 490423, Long Term Care Budget - State, and 490623, Long Term Care Budget, may be used to provide the preadmission screening and resident review (PASRR), which includes screening, assessments, and determinations made under sections 5111.02, 5111.204, 5119.061, and 5123.021 of the Revised Code.

The foregoing appropriation items 490423, Long Term Care Budget - State, and 490623, Long Term Care Budget, may be used to assess and provide long-term care consultations to clients regardless of Medicaid eligibility.

The Director of Aging shall adopt rules under section 111.15 of the Revised Code governing the nonwaiver funded PASSPORT program, including client eligibility. The foregoing appropriation item 490423, Long Term Care Budget - State, may be used by the Department of Aging to provide nonwaiver funded PASSPORT services to persons the Department has determined to be eligible to participate in the nonwaiver funded PASSPORT Program, including those persons not yet determined to be financially eligible to participate in the Medicaid waiver component of the PASSPORT Program by a county department of job and family services.

The Department of Aging shall administer the Medicaid waiver-funded PASSPORT Home Care Program, the Choices Program, the

Assisted Living Program, and the PACE Program as delegated by the 1353
Department of Job and Family Services in an interagency agreement. 1354
The foregoing appropriation item 490423, Long Term Care Budget - 1355
State, shall be used to provide the required state match for 1356
federal Medicaid funds supporting the Medicaid Waiver-funded 1357
PASSPORT Home Care Program, the Choices Program, the Assisted 1358
Living Program, and the PACE Program. The foregoing appropriation 1359
items 490423, Long Term Care Budget - State, and 490623, Long Term 1360
Care Budget, may also be used to support the Department of Aging's 1361
administrative costs associated with operating the PASSPORT, 1362
Choices, Assisted Living, and PACE programs. 1363

The foregoing appropriation item 490623, Long Term Care 1364
Budget, shall be used to provide the federal matching share for 1365
all program costs determined by the Department of Job and Family 1366
Services to be eligible for Medicaid reimbursement. 1367

HOME FIRST PROGRAM 1368

(A) As used in this section, "Long Term Care Budget Services" 1369
includes the following existing programs: PASSPORT, Assisted 1370
Living, Residential State Supplement, and PACE. 1371

(B) On ~~a quarterly basis, on~~ receipt of the certified 1372
expenditures related to sections 173.401, 173.351, 173.501, and 1373
5111.894 of the Revised Code, the Director of Budget and 1374
Management, in consultation with the Directors of Aging and Job 1375
and Family Services, may do all of the following for fiscal years 1376
2010 and 2011: 1377

(1) Transfer cash from the Nursing Facility Stabilization 1378
Fund (Fund 5R20), used by the Department of Job and Family 1379
Services, to the PASSPORT/Residential State Supplement Fund (Fund 1380
4J40), used by the Department of Aging. The 1381

~~The~~ transferred cash is hereby appropriated to appropriation 1382
item 490610, PASSPORT/Residential State Supplement. 1383

(2) ~~If receipts credited to~~ Authorize expenditures from the 1384
PASSPORT Fund (Fund 3C40) for amounts that exceed the amounts 1385
appropriated from receipts credited to the fund, ~~the Director of~~ 1386
~~Aging may request the Director of Budget and Management to~~ 1387
~~authorize expenditures from the fund in excess of the amounts~~ 1388
~~appropriated. Upon the approval of the Director of Budget and~~ 1389
~~Management, the~~ Any additional authorized amounts are hereby 1390
appropriated. 1391

(3) ~~If receipts credited to~~ Authorize expenditures from the 1392
Interagency Reimbursement Fund (Fund 3G50) for amounts that exceed 1393
the amounts appropriated from receipts credited to the fund, ~~the~~ 1394
~~Director of Job and Family Services may request the Director of~~ 1395
~~Budget and Management to authorize expenditures from the fund in~~ 1396
~~excess of the amounts appropriated. Upon the approval of the~~ 1397
~~Director of Budget and Management, the~~ Any additional authorized 1398
amounts are hereby appropriated. 1399

(C) Not later than thirty days after the Director of Budget 1400
and Management receives certification of expenditures specified in 1401
division (B) of this section, the Executive Director of Executive 1402
Medicaid Management Administration shall submit a report to the 1403
General Assembly in accordance with section 101.68 of the Revised 1404
Code and to the chairs and ranking minority members of the 1405
committees of the House of Representatives and Senate to which the 1406
biennial budget bill is referred. The report shall describe and 1407
document the criteria and data the Department of Aging, Department 1408
of Job and Family Services, and Office of Budget and Management 1409
use to justify a transfer of funds under division (B) of this 1410
section, including spending and utilization trends for PASSPORT, 1411
PACE, assisted living, and nursing facility services. In addition 1412
to providing the information for the transfer of funds, the report 1413
shall include the following: 1414

1415

(1) In the case of reports for transfers that occur during 1416
fiscal year 2010, the descriptions and documents of the criteria 1417
and data used to justify other such transfers that previously 1418
occurred during that fiscal year; 1419

(2) In the case of reports for transfers that occur during 1420
fiscal year 2011, the descriptions and documents of the criteria 1421
and data used to justify other such transfers that previously 1422
occurred during that fiscal year and fiscal year 2010. 1423

The Directors of Aging, Job and Family Services, and Budget 1424
and Management shall provide the Executive Director of the 1425
Executive Medicaid Management Administration with all information 1426
the Executive Director needs to prepare the reports required by 1427
this division. 1428

(D) The individuals placed in Long Term Care Budget Services 1429
pursuant to this section shall be in addition to the individuals 1430
placed in Long Term Care Budget Services during fiscal years 2010 1431
and 2011 before any transfers to appropriation item 490423, Long 1432
Term Care Budget-State, are made under this section. 1433

ALLOCATION OF PACE SLOTS 1434

In order to effectively administer and manage growth within 1435
the PACE Program, the Director of Aging may, as the director deems 1436
appropriate and to the extent funding is available, expand the 1437
PACE Program to regions of Ohio beyond those currently served by 1438
the PACE Program. In implementing the expansion, the Director may 1439
not decrease the number of residents of Cuyahoga and Hamilton 1440
counties and parts of Butler, Clermont, and Warren counties who 1441
are participating in the PACE Program below the number of 1442
residents of those counties and parts of counties who were 1443
enrolled in the PACE Program on July 1, 2008. 1444

Section 4. That existing Section 209.20 of Am. Sub. H.B. 1 of 1445

the 128th General Assembly is hereby repealed. 1446

Section 5. During fiscal years 2012 and 2013, on receipt of 1447
certified expenditures related to sections 173.401, 173.351, 1448
173.501, and 5111.894 of the Revised Code, the Director of Budget 1449
and Management shall transfer cash from the Nursing Facility 1450
Stabilization Fund (Fund 5R20), used by the Department of Job and 1451
Family Services, to the PASSPORT/Residential State Supplement Fund 1452
(Fund 4J40), used by the Department of Aging. 1453

If receipts credited to the PASSPORT Fund (Fund 3C40) exceed 1454
the amounts appropriated from the fund in fiscal years 2012 and 1455
2013, the Director of Aging shall request the Director of Budget 1456
and Management to authorize expenditures from the fund in excess 1457
of the amounts appropriated. 1458

If receipts credited to the Interagency Reimbursement Fund 1459
(Fund 3G50) exceed the amounts appropriated from the fund in 1460
fiscal years 2012 and 2013, the Director of Job and Family 1461
Services shall request the Director of Budget and Management to 1462
authorize expenditures from the fund in excess of the amounts 1463
appropriated. 1464

Section 6. (A) As used in this section, "population" means 1465
that shown by the 2000 regular federal census. 1466

(B) Until December 31, 2010, the Director of Health shall 1467
accept, for review under section 3702.52 of the Revised Code, 1468
certificate of need applications for an increase in beds in an 1469
existing nursing home if all of the following conditions are met: 1470

(1) The proposed increase is attributable solely to a 1471
relocation of beds registered under section 3701.07 of the Revised 1472
Code as long-term care beds from an existing hospital located in a 1473
county with a population of at least forty thousand persons and 1474

not more than forty-five thousand persons to an existing nursing 1475
home located in a county that has a population of at least one 1476
million persons and not more than one million one hundred thousand 1477
persons and is contiguous to the county from which the beds are to 1478
be relocated. 1479

(2) Not more than fifteen beds are proposed for relocation. 1480

(3) After the proposed relocation, there will be existing 1481
long-term care beds, as defined in section 3702.51 of the Revised 1482
Code, remaining in the county from which the beds are relocated. 1483

(4) The beds are proposed to be licensed as nursing home beds 1484
under Chapter 3721. of the Revised Code. 1485

(C) In reviewing a certificate of need application accepted 1486
under this section, the Director shall not deny the application on 1487
the grounds that the existing hospital from which the beds are to 1488
be relocated is not providing services in all or part of the 1489
long-term care beds at the hospital or has not provided services 1490
in all or part of those long-term care beds for at least three 1491
hundred sixty-five days within the twenty-four months immediately 1492
preceding the date the certificate of need application is filed 1493
with the Director, as otherwise required by a rule adopted under 1494
section 3702.57 of the Revised Code. 1495