Washington State Department of Health
Certificate of Need Program
P.O. Box 47852
Olympia, Washington 98502-7852

Official Use Only-Date Received:

APPLICATION FOR CERTIFICATE OF NEED
Nursing Home Projects
(Excluding CCRC)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 Revised Code of Washington (RCW) and Rules and Regulations adopted by the Department (WAC 246-310). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

APPLICANT(S)

OWNER:

_____
Name and Title of Responsible Officer
(PLEASE PRINT OR TYPE)
Legal Name of Owner:

_____
Address of Owner:

_____

_____

_____
Signature of Responsible Officer

Date: _____ Telephone: _____

OPERATOR:

_____
Name and Title of Responsible Officer
(PLEASE PRINT OR TYPE)
Legal Name of Operator:

_____
Address of Operator:

_____

_____

_____
Signature of Responsible Officer

Date: _____ Telephone: _____

TYPE OF OWNERSHIP:
[ ] District
[ ] Private Non-Profit
[ ] Proprietary - Corporation
[ ] Proprietary - Individual
[ ] Proprietary - Partnership
[ ] State or County

Proprietor(s) or Stockholder(s) information:
Provide the name and address of each owner and indicate percentage of ownership:

_____
_____
_____
_____
_____

Intended Project Start Date: _____
ESTIMATED CAPITAL EXPENDITURE: $_____

OPERATION OF FACILITY:
[ ] Owner Operated
[ ] Management Contract
[ ] Lease

TYPE OF PROJECT *(check all that apply):*
[ ] Total Replacement of Existing Facility
[ ] New Facility
[ ] Renovation/Modernization
[ ] Bed Addition
[ ] Capital Expenditure Over the Minimum
[ ] Bed Capacity Change/Redistribution
[ ] New Institutional Health Service
[ ] Mandatory Correction of Fine/Deficiencies
[ ] Amend Current Certificate of Need
[ ] Expansion/Reduction of Physical Plant
[ ] Other _____

Intended Project Completion Date: _____

Project Description: _____
_____
_____
_____

ATTACH NARRATIVE PORTION OF THE APPLICATION

INSTRUCTIONS FOR SUBMISSION: DO NOT bind your application. Bindings, notebooks and other covers are not necessary. Please number the pages at the bottom, and two-hole punch the application material at the top of the pages.

1. Mail two copies of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Or

To mail overnight, UPS or FedX

Department of Health
Certificate of Need Program
111 Israel Road SE
Olympia, Washington 98501

The application must be accompanied by a check, payable to: ***Department of Health***.
TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: $46,253

APPLICANT NAME: _____

DATE OF SUBMISSION: _____ CHECK NUMBER: _____

INSTRUCTIONS FOR COMPLETION OF RATIO INFORMATION
FOR ALL NURSING HOME PROJECTS

Utilizing the data from the financial statement submitted in the application, calculate the debt services coverage, current ratio, assets financed by liabilities ratio, and the total operating expenses to total operating revenue ratio. The method of calculating these ratios is listed below. Enter the ratio figures in the table on the next page. The normal or expected value for each of these ratios is: Debt Service Ratio 1.5 - 2.0; Current ratio 1.8 - 2.5; Assets Financed by Liabilities Ratio 0.6 - 08; and Total Operating Expense to Total Operating Revenue ratio 1.0. If the project's calculated ratios are outside the normal or expected range, please explain.

METHOD FOR CALCULATING FINANCIAL RATIOS

For each financial or calendar year, as appropriate, calculate the current ratio, the assets financed by liabilities ratio, the total operating expense to total operating revenue ratio, and the debt service coverage ratio:

RATIO	CALCULATION	LINE ITEMS
Current Ratio	Current Assets --- Current Liabilities	Schedule B, Line 14 --- Schedule B, Line 50
Assets Financed by Liabilities	Current Liabilities + Long Term Liabilities --- Total Assets	Schedule B, Line 50 + 60 --- Schedule B, Line 39
Total Operating Expense to Total Operating Revenue	Total Operating Expense --- Net Operating Revenue	Schedule C, Line 22 --- Schedule C, Line 9
Debt Service Coverage	Net Income + Interest Expense + Depreciation --- Current Portion of Long-Term Debt + Interest Expense	Schedule C, Line 28 + Schedule G, Line 160 + 158 --- Schedule B, Line 44 + Schedule G, Line 160

The financial ratios should be entered on the financial ratio table shown on page 5.

APPLICATION INFORMATION INSTRUCTIONS

These application information requirements are to be used in preparing a Certificate of Need application.

The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 78.38.115 and WAC 246-310-210, 220, 230, 240, 370, and 380.

- The application must be submitted with a completed and signed Certificate of Need application face sheet and the appropriate review and processing fee. Send the original and a CD of the application to:

  Department of Health
  Certificate of Need Program
  P O Box 47852
  Olympia, Washington 98504-7852

- Submit a copy of the **Letter of Intent** for this project in the application.

- Please make the narrative information complete and concise. Data sources are to be cited. Extensive supporting data, that would tend to interrupt the narrative, should be placed in the appendix.

- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all proforma data and projections. **DO NOT** inflate these dollar amounts.

- Capital expenditures should not include contingencies. Certificate of Need statute and regulation allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate of Need is required.

APPLICATION INFORMATION REQUIREMENTS FOR NURSING HOME PROJECTS

I. APPLICANT DESCRIPTION:

Note: The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership, corporation, or other comparable legal entity or lessee that engages in any undertaking subject to review under provisions of RCW 70.38.

A. OWNER DESCRIPTION

1. Legal name(s) of owner(s)
2. Address of each owner
3. Provide the following information about each owner:
   a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division. Show relationship to any organization as defined in Section 405.427 of the Medicare Regulations.
   b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

B. OPERATOR DESCRIPTION

1. Legal name and address of operating entity (unless same as owner).
   a. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.
   b. If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.
   c. Is the applicant currently, or does the applicant propose to be reimbursed for services provided under Title V, Title XVIII, and/or Title XIX of the Social Security Act?
   d. Name, title, address, and telephone number of the person to whom questions regarding this application should be directed.
   e. Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each out-of-state facility, provide the name, address, telephone number, and contact person for the entity responsible for the licensing/survey of each facility.

II. FACILITY DESCRIPTION

A. Name and address of the proposed/existing facility.

B. Provide the following information:

	Nursing Home (SNF/ICF)	Boarding Home (Cong.)
Total number of beds currently licensed	_____	_____
Total number of beds currently set-up	_____	_____

III. PROJECT DESCRIPTION

Note: An amended Certificate of Need shall be required if certain modifications are made to a project for which a Certificate of Need was issued in accordance with WAC 246-310-570.

A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space, as well as the construction of new facility space. Also, specify any unique services being proposed.

B. Health Services (check all in each column that apply):

Table I

TYPES OF THERAPY	***SUPPORT SERVICES***	***CURRENT SERVICES***	***PROPOSED SERVICES***
Physical Therapy	Inpatient		
Physical Therapy	Outpatient		
Speech Therapy	Inpatient		
Speech Therapy	Outpatient		
Occupational Therapy	Inpatient		
Occupational Therapy	Outpatient		
Nursing Services	Outpatient		
Meals on Wheels	Outpatient		
Adult Day Care	Outpatient		
Other (specify)	Outpatient		

C. Increase in total licensed beds or redistribution of beds among facility and service categories of skilled nursing and boarding home care:

D. Indicate if the nursing home would be Medicaid certified. Yes _____ No _____

E. Indicate if the nursing home would be Medicare eligible. Yes _____ No _____

Indicate the number of Medicare certified beds. Current _____ Proposed _____

F. Description of new equipment proposed, including cost of the equipment.

G. Description of equipment to be replaced, including cost of equipment and salvage value *(if any)* or disposal or use of the equipment to be replaced.

H. Blueprint size schematic drawings to scale of current locations of patient rooms, ancillary departments, and support services.

I. Blueprint size schematic drawings to scale of proposed locations of patient rooms, ancillary department, and support services, *clearly differentiating between remodeled areas and new construction.*

J. Geographic location of site of proposed project.

1. Indicate the number of acres in nursing home site: Acres _____

2. Indicate the number of acres in any alternate site for the nursing home *(if applicable)*
   Acres _____

3. Indicate if the primary site or alternate site has been acquired *(if applicable)*
   Yes ____ No ____

Address of site: _____

Address of alternate site: _____

4. If the primary site or alternate site has not been acquired, explain the current status of the site acquisition plans, including proposed time frames.

Note: If approved, the Certificate of Need will specify the site and/or alternate site of the project. A change of location of the site authorized by the Certificate of Need may require an amendment to the Certificate of Need.

5. Demonstration of sufficient interest in project site. Provide a copy of a clear legal title to the proposed site and **one** of the following:
   a. Lease for at least five years, with options to renew for not less than a total of twenty years; or
   b. Legal, enforceable agreement to give such title or such lease in the event a Certificate of Need is issued.

6. Demonstration that the proposed site may be used for the proposed project. Please include a letter from the appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project, or a written explanation of why the proposed purpose is exempt.

K. Space Requirements

1. Existing gross square footage. _____

2. Total gross square footage for the proposed addition and the existing facility. _____

3. Proposed new facility gross square footage. _____

4. Do the above responses include any shelled-in areas? Yes _____ No _____

If yes, please explain the type of shelled-in space proposed (administration, patient beds, therapy space, etc.)

_____

_____

_____

L. Proposed Timetables for Project Implementation:

Note: The Certificate of Need Program will use the following time tables in monitoring the applicant's conformance with the issued Certificate of Need. Failure to meet the timetable specified below may be grounds for withdrawal of a Certificate of Need. (WAC 246-310-600 (1)).

1. Financing:
   a. Date for obtaining <u>construction</u> financing. Month _____ Year _____

   b. Date for obtaining <u>permanent</u> financing. Month _____ Year _____

   c. Date for obtaining funds necessary to undertake the project.
   Month _____ Year _____

2. Design
   a. Date for completion and submittal of preliminary drawings to Consultation and Construction Review Section . Month _____ Year _____
   b. Date for completion and submittal of final drawings and specifications to Consultation and Construction Review Section . Month _____ Year _____

3. Construction
   a. Date for construction contract award. Month _____ Year _____

   b. Date for 25 percent completion of construction *(25 percent of the dollar value of the contract in place)*. Month _____ Year _____

   c. Date for 50 percent completion of construction.
   Month _____ Year _____

   d. Date for 75 percent completion of construction.
   Month _____ Year _____

   e. Date for completion of construction. Month _____ Year _____

f. Date for obtaining licensure approval. Month _____ Year _____

g. Date for occupancy/offering of service(s). Month _____ Year _____

M. As the applicant(s) for this project, please describe your experience and expertise in the planning, developing, financing, and construction of skilled nursing and intermediate care facilities.

IV. PROJECT RATIONALE

Provide documentation to establish conformance of the project with applicable review criteria.

A. NEED: (WAC 246-310-210 and WAC 246-310-380 (6))

1. Identify and analyze the unmet health service need and/or other problems to which this project is directed.

a. Describe the need of the people you plan to serve for the service you propose.

b. Address the need for nursing home beds based on the 45 beds per 1,000 population and Substitute House Bill 2098, which encourages the development of a broad array of home and community-based long-term care services as an alternative to nursing home care.

2. If your proposal exceeds the number of beds identified as needed in your county nursing home planning area as shown in WAC 246-310-380 (6), please discuss how the approval of beds beyond the projected need would further the policy that beds should be located reasonably close to the people they serve.

3. Provide utilization data for each of the last three full fiscal years, the current annualized full fiscal year, and the next three full fiscal years: *(USE SCHEDULE A which is attached to these guidelines*.)

4. In the case of any proposed conversion of beds from other service categories to nursing care beds, provide evidence that the conversion will not jeopardize the availability of service. Document the availability and accessibility of the services that are to be converted.

5. In the context of the criteria contained in WAC 246-310-210 (2) (a) and (b), please describe how the service will be available to the following: low-income individuals, racial and ethnic minorities, women, handicapped individuals, elderly, and other under-served individuals.

6. Does/will the facility require a pre-admission deposit? Please explain the intent and use of the deposit.

7. Please submit copies of the facility's admission agreement, policies, and procedures.

8. If you propose any special services including, but not limited to, heavy care, Alzheimer's care, respite care, and adult day care, please provide the following:

a. Describe the service in full detail.

b. Include program content, staffing by classification and FTE commitment, budget, and the amount of space dedicated to each service.

c. Document the need for any special services.

9. If the purpose of the project is to correct existing structure, fire, and/or life-safety code deficiencies, or licensing, accreditation, or certification standards as provided for under provisions of WAC 246-310-480, provide a detailed description of the cited deficiencies and attach copies of the two most recent Fire Marshal's surveys and/or surveys conducted by the Survey Program, Aging and Adult Services Administration, Department of Social and Health Services, or other surveying agency.

B. FINANCIAL FEASIBILITY (WAC 246-310-220)

APPLICANTS MUST COMPLETE ONE OF THE FOLLOWING SECTIONS AS APPROPRIATE: SECTION I, SECTION II, SECTION III, OR SECTION IV. ***ALL APPLICANTS MUST COMPLETE SECTION V.***

SECTION I:
Applicants proposing to construct a new nursing home or replace an existing nursing home on the same or a new site, should complete this section for the development of the building cost per bed and reasonable land cost.

The information requested in Section I must be provided by a licensed architect or engineer.

Indicate the name, address, and telephone number of the licensed architect or engineer that completed this section:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

Proposed Site Address: _____ Zip Code: _____

The following Part I, Reasonable Building Cost Guidelines, and Part II, Reasonable Land Cost Guidelines, will be utilized to determine whether or not the building cost per bed and land cost are reasonable. These guidelines are based on WAC 388-96-745.

PART I -- REASONABLE BUILDING COST GUIDELINES

1. The Marshall Valuation Services *(updated August 1993)* Section I, pages 3-12, describes the building class (A, B, C, and D) and the building quality (excellent, good, average, and low cost) of the building. Based on this description, state the building class and building quality that is proposed for construction by this project. Applicants proposing to add beds at an existing nursing home should also state the building class and building quality of the existing nursing home.

For New Construction:
Class _____ Quality _____ Number of Beds _____

For Existing Construction:
Class _____ Quality _____ Number of Beds _____

2. Indicate the total number of square feet of construction that is proposed including walls, partitions, stairwells, etc. Total Square Feet _____

3. The Marshall Valuation Services *(updated August 1993)* Section I, pages 3-12, describes the type of materials that can be utilized to construct the frame, floor, roof, and walls of a building. Based on this description, indicate the type of materials that would be utilized in the following major components of the proposed building.

ITEM	***TYPE OF MATERIAL***
Frame	
Floor	
Roof	
Wall Structures	
Exterior Finish	
Interior Finish	
Lighting, Plumbing, and Mechanical	
Heating and Cooling	

4. Indicate the total cost of constructing the new nursing home, replacing the existing nursing home, or constructing a bed addition at the nursing home. In cases where a nursing home/boarding home facility shares a common foundation and roof, the cost of the shared items shall be apportioned to the nursing home based on the Medicare program methodology for apportioned costs to the nursing home service. Construction costs shall include the following:

ITEM	***COST***
a. Land Purchase	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (which is not included in construction contract)	$
h. Movable Equipment	$
i. Architect and Engineering Fees	$
j. Consulting Fees	$
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Costs Associated with Securing the Source(s) of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
o. Other Projected Costs - itemize	$
1.	$
2.	$
3.	$
4.	$
p. ***TOTAL ESTIMATED CAPITAL COST (ACTUAL/REPLACEMENT COST)***	**$**

5. Provide a copy of a signed non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect, and engineering fees, site preparation, supervision, and inspection of site, Washington Sate sales tax, and other projects costs (items c, f, i, k, m, n, and o above).

6. The reasonableness of building construction cost is based on the data shown in the table shown on the next page entitled, "Cost Guidelines for New Building and Improvements Plus Increments for Additional Beds." Reasonable building costs will be determined by:

   a. Locating the class of construction (A, B, C, or D) and quality of construction (good, average, low) in the table, multiply the number of beds proposed by the appropriate per bed base cost;

   b. Identify the appropriate base cost for the facility (using the same class and quality of construction);

c. Additional incremental allowances are allowed for projects requesting beds between 75-120 and projects of over 120 beds.

c1. For projects greater than 74 beds, but less than 121 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds between 75 to 120: ***or***

c2. For projects greater than 120 beds, multiply the appropriate per bed incremental allowance (using the same class and quality of construction) by the number of additional beds over 75, but less than 120, then multiply the appropriate incremental allowance by the number of beds over 120 and add these two figures together.

7. The figures from 6a, 6b, and 6c, when applicable, are added to determine the construction cost lids. Final lid values will be adjusted for inflation using the actual change in the appropriate cost indexes.

REASONABLE COST GUIDELINES FOR THE NEW BUILDING, PLUS INCREMENTS FOR ADDITIONAL BEDS

Building Class	***For 0 -- 74 Bed Facilities***	***For 75 - 120 Bed Facilities***		***For 121+ Bed Facilities***	
	Add per bed	***Add this base***	***Per additional beds over 74***	***Add this base***	***Per additional beds over 74***
a. Good	51,222	3,790,442	48,964	6,042,793	43,022
a. Average	41,822	3,094,834	39,978	4,933,842	35,127
b. Good	49,257	3,645,006	47,085	5,810,935	41,371
b Average	40,736	3,014,461	38,940	4,805,710	34,214
c. Good	36,499	2,700,943	34,890	4,305,894	30,656
c. Average	28,159	2,083,794	26,918	3,322,023	23,651
c. Low	22,143	1,638,554	21,167	2,612,213	18,598
d. Good	33,728	2,495,865	32,241	3,978,954	28,328
d. Average	26,104	1,931,660	24,953	3,079,488	21,925
d. Low	20,630	1,526,606	19,720	2,433,744	17,327

ADD FOR COMMON USE AREAS

	Building Class	***Add entire amount***	***Add this base***	***Add for additional beds over 74***	***Add this base***	***Add for additional beds over 120***
118.845	a. Good	289,625	289,625	2,971	426,297	2,377
97.035	a. Average	236,744	236,474	2,426	348,065	1,941
114.285	b Good	278,513	278,513	2,857	409,940	2,286

94.515	b. Average	230,333	230,333	2,363	339,025	1,890
84.685	c. Good	206,377	206,377	2,117	303,765	1,694
65.335	c. Average	159,221	159,221	1,633	234,357	1,307
51.375	c. Low	125,201	125,201	1,284	184,282	1,028
78.255	d. Good	190,707	190,707	1,956	280,701	1,565
60.565	d. Average	147,597	147,597	1,514	217,247	1,211
47.865	d. Low	116,647	116,647	1,197	171,692	957

8. The above estimated building costs per bed may be adjusted when the following circumstances apply to the project.

    a. Construction changes required by Facilities and Services Licensing Section, Office of Resource Development, and/or Department of Health in the course of approving the building plans for the project.

    b. Four story or higher construction.

    c. Unusual labor or climatic conditions at time of construction that were not foreseeable by management.

    d. Cost savings realized in other components of the project such as equipment or operating costs.

    e. Where more than one major construction type is present, an average facility type shall be computed by weighing relative costs of the framing, floor, roof, and walls.

Applicants requesting adjustments to the guidelines for responsible building cost per bed shall provide written justification and a financial analysis showing the rationale for the adjustments.

PART II -- REASONABLE LAND COST GUIDELINES

1. The land cost guidelines are for land that is utilized by the nursing home service. When an applicant proposes to construct a new nursing home/boarding home facility, the amount of land utilized by the nursing home services should be calculated based on Medicaid program methodology for apportioning costs to the nursing home for reimbursement purposes. Based on the above factors, the cost of land, plus cost of utilities to lot line for the proposed nursing home would be: $ _____

2. Indicate the number of square feet of land that would be utilized for the nursing home service: _____ square feet

3. Indicate the cost per square foot for the utilized by the nursing home service: $._____

4. Exceptions to square foot cost lids (WAC 388-96-745 (7)) may be allowed to a maximum of ten percent (WAC 388-96-754(8)). An adjustment shall be granted only if requested by the applicant. Applicants requesting adjustments to the guidelines for reasonable land costs shall provide written justification and an analysis showing the rationale for the adjustments.

5. Exceptions to land area lids (WAC 388-96-762) may be allowed. An adjustment shall be granted only if requested by the applicant and meet the criteria defined in WAC 388-96-762(3). Applicants requesting adjustments to the guidelines for area land lids shall provide written justification and an analysis showing the rationale for the adjustments.

Questions regarding the construction cost lid exception process should be directed to the Residential Rates Program of Aging and Adult Services.

SECTION II

Applicants proposing to add beds at an existing nursing home or remodel a nursing home at a cost in excess of the Capital Expenditure Threshold should complete this section for the calculation of property and return on investment rate.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address and phone number of the licensed architect or engineer that completed section.

Name:.....
Address.....
Phone Number:.....

Proposed Site Address.....
Zip Code.....

1. Indicate the total cost of constructing the bed addition or the cost of remodeling an existing nursing home. In cases where a nursing home/boarding home facility shares a common foundation and roof, etc., the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall include the following:

ITEM	***COST***
a. Land Purchase	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (which is not included in construction contract)	$
h. Movable Equipment	$
i. Architect and Engineering Fees	$
j. Consulting Fees	$
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Costs Associated with Securing the Source(s) of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
o. Other Projected Costs - itemize	$
1.	$
2.	$
3.	$
4.	$
p. ***TOTAL ESTIMATED CAPITAL COST (ACTUAL/REPLACEMENT COST)***	**$**

2. Provide a copy of a signed, non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n, and o above).

3. Estimated Nursing Home Construction Costs

	Estimated Square Footage	Construction Cost Square Footage (use f, g, & k)	Total Cost per Bed (use p)	Total Cost per Square Footage (use p)

Nursing Home				

4. For an existing facility, indicate the incremental increase in capital costs per patient day that would result from this project using the chart below

	Current Year	*Year 1*	*Year 2*	*Year 3*
Total Depreciation Expenses				
Total Interest Expenses				
Total Capital Expenditure				
Patient Days				
Capital Cost per Patient Day (c/d)				

SECTION III:
Applicants proposing to amend a Certificate of Need should complete this section for the calculation of property and return on investment rate.

The information requested in this section must be provided by a licensed architect or engineer.

Indicate the name, address, and phone number of the licensed architect or engineer that completed this section.

Name:.....
Address.....
Phone Number:.....

Proposed Site Address.....
Zip Code.....

1. Indicate the total cost of constructing the new nursing home. In cases where a nursing home/boarding home facility share a common foundation and roof, the cost of the shared items shall be apportioned to the nursing home based on the Medicaid program methodology for apportioning costs to the nursing home service. Construction costs shall including the following:

ITEM	***ORIGINAL COST***	***AMENDED COST***
a. Land Purchase	$	$
b. Utilities to Lot Line	$	$
c. Land Improvements	$	$
d. Building Purchase	$	$
e. Residual Value of Replaced Facility	$	$
f. Building Construction	$	$
g. Fixed Equipment (which is not included in construction contract)	$	$
h. Movable Equipment	$	$
i. Architect and Engineering Fees	$	$
j. Consulting Fees	$	$
k. Site Preparation	$	$
l. Supervision and Inspection of Site	$	$
m. Costs Associated with Securing the Source(s) of Financing (include interim interest during construction)		
1. Land	$	$
2. Building	$	$
3. Equipment	$	$
4. Other	$	$
n. Washington Sales Tax	$	$
1. Land	$	$
2. Building	$	$
3. Equipment	$	$
4. Other	$	$
o. Other Projected Costs - itemize	$	$
1.	$	$
2.	$	$
3.	$	$
4.	$	$
p. ***TOTAL ESTIMATED CAPITAL COST***	**$**	**$**

2. Provide a copy of a signed, non-binding cost estimate or contractor's estimate of the project's land improvements, building construction cost, architect and engineering fees, site preparation, supervision and inspection of site, Washington State sales tax, and other project costs (Items c, f, i, k, m, n, and o above).

3. Provide a brief description of the contractor's or cost estimator's experience with nursing home projects.

4. Estimated Nursing Home Construction Costs

	Estimated Square Footage	Construction Cost Square Footage (use f, g, & k)	Total Cost per Bed (use p)	Total Cost per Square Foot (use p)
Nursing Home	Orig: --- Amd'd:	Orig: --- Amd'd:	Orig: --- Amd'd:	Orig: --- Amd'd:

5. For an existing facility, indicate the incremental increase in capital cost per patient day that would result from this project using the chart below:

ORIGINAL	Current Year	Year 1	Year 2	Year 3
Total Depreciation Expenses				
Total Interest Expenses				
Total Capital Expenditure				
Patient Days				
Capital Cost per Patient Day (c/d)				

AMENDED	Current Year	Year 1	Year 2	Year 3
Total Depreciation Expenses				
Total Interest Expenses				
Total Capital Expenditure				
Patient Days				
Capital Cost per Patient Day (c/d)				

SECTION IV:

All applicants must provide interest rate, source of financing project costs, estimated start-up-initial operating deficits, financial statements, and projected patient charges.

1. Identify the owner or operator who will incur the debt for the proposed project.

2. Anticipated sources and amounts of financing for the project (actual sources for conversions)

	Specify Type	Dollar Amount
Public Campaign		$
Bond Issue		$
Commercial Loans		$
Government Loans		$
Grants		$
Bequests & Endorsements		$
Private Foundations		$
Accumulated Reserves		$
Owner's Equity		$
Other - (specify)		$
Other - (specify)		$
TOTAL (must equal total Project Cost		$

3. Provide a complete description of the methods of financing which were considered for the proposed project. Discuss the advantages of each method in terms of costs and explain why the specific method(s) to be utilized was (were) selected.

4. Indicate the anticipated interest rate on the loan for constructing the nursing home.....%

5. Indicate if the interest rate will be fixed or variable on the long-term loan and indicate the rate of interest.

   Fixed interest rate.....%

   Variable interest rate beginning at.....% and ending at.....%

   Loan terms.....

6. Estimated start-up and initial operating expenses

a. Total estimated start-up costs $..... (*expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicaid guidelines for start-up costs*)

b. Estimated period of time necessary for initial start-up:.....months (*period of time after construction completed, but prior to receipt of patients)*

c. Total estimated initial operating deficits $..... *(operating deficits occurring during initial operating period)*

d. Estimated initial operating period.....months (*period of time from receipt of first patient until total revenues equal total expenses*)

7. Anticipated Sources of Financing Start-up and Initial Operating Deficits.

Unrestricted Cash of Proponent	$
Unrestricted Marketable Securities of Proponent	$
Accounts Receivable	$
Commercial Loan	$
Line of Credit (*specify source*)	$
Other (*specify*)	$
TOTAL	**$**

8. Evidence of Availability of Financing for the Project

Please submit the following:

a. Copies of letter(s) from the lending institution indicating a willingness to finance the proposed project (*both construction and permanent financing*). The letter(s) should include:

i. Name of person/entity applying
ii. Purpose of the loan(s)
iii. Proposed interest rate(s) (fixed or variable)
iv. Proposed term (*period)* of the loan(s)
v. Proposed amount of loan(s)

b. Copies of letter(s) from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 8(a) above, as applicable.

c. Copies of each lease or rental agreement related to the proposed project.

d. Separate amortization schedule(s) for each financing arrangement including long-term and any short-term start-up, initial operating deficit loans, and refinancing of the facility's current debt setting forth the following:

i. Principal
ii. Term (*number of payment period, long-term loans may be annualize*)
iii. Interest
iv. Outstanding balance of each payment period

9. Provide the following:
   a. Please supply copies of the following pages and accompanying footnotes of each applicant's three most recent financial statements: Balance Sheet, Revenue and Expense, and Changes in Financial Position. (*If not available as a subsidiary corporation, please provide parent company's statements, as appropriate*.)

   b. Please provide the following facility-specific financial statements through the third complete fiscal year following project completion. Identify all assumptions utilized in preparing the financial statements.

      i. Schedule B Balance Sheet
      ii. Schedule C Statement of Operations
      iii. Schedule D This Statement Has Been Eliminated
      iv. Schedule E Statement of Changes in Equity/Fund Balance
      v. Schedule F Notes to Financial Statements
      vi. Schedule G Itemized Lists of Revenue and Expenses
      vii. Schedule H Debt Information
      viii. Schedule I Book Value of Allowable Assets

NOTE: USE SCHEDULES ATTACHED TO THESE GUIDELINES.

10. Utilizing the data from the financial statements, please calculate the following:

    a. Debt Service Coverage
    b. Current Ratio
    c. Assets Financed by Liabilities Radio
    d. Total Operating Expense to Total Operating Revenue

NOTE: USE FORMS ATTACHED TO THESE GUIDELINES.

11. If the project's calculated ratios are outside the normal or expected range, please explain.

12. If a financial feasibility study has been prepared, either by or on behalf of the proponent in relation to this project, please provide a copy of that study.

13. Current and Projected Charges and Percentage of Patient Revenue

    a. Per Diem Charges for Nursing Home Patients for Each of the Last Three Fiscal Years:

	19___	19___	19___
Private Pay			
Medicaid			
Medicare			
VA			
Other-Specify			

    b. Current Average Per Diem Charges for Nursing Home Patients:

Current Year

Private Pay	
Medicaid	
Medicare	
VA	
Other-Specify	

c. Projected Average Per Diem Charges for Nursing Home Patients for Each of the First Three Years of Operation:

	19___	19___	19___
Private Pay			
Medicaid			
Medicare			
VA			
Other-Specify			

d. Please indicate the percentage of patient revenue that will be received for the:

Existing Facility	
Private Pay	%
Medicaid	%
Medicare	%
VA	%
Other-Specify	%

Proposed Facility (expansion)	
Private Pay	%
Medicaid	%
Medicare	%
VA	%
Other-Specify	%

C. STRUCTURE AND PROCESS (QUALITY) OF CARE (WAC 246-310-230)

1.

Staffing	**Current Number of Employees**		**Projected Number of Employees**	
	Full-Time Equivalent	*Consultant hr/week*	*Full-Time Equivalent*	*Consultant hr/week*
Registered Nurse				
LPN				
Nurses Aides & Assistants				
NURSING TOTAL				
Dietitians				
Aides				
DIETARY TOTAL				
Administrator				
Assistant Administrator				
Administrator In-training				
Activities Director				
Medical Director				
In-service Director				
Director of Nursing				
Clerical				
Housekeeping/ maintenance				
Laundry				
ADMINISTRATION TOTAL				
Physical Therapist				
Occupational Therapist				
Pharmacist				
Medical Records				
Social Worker				
Plant Engineer				
Other (specify)				
ALL OTHERS TOTAL				
TOTAL STAFFING				

2. Nursing hours per patient day

Registered Nurse	
LPNs	
Nurse's Aides & Assistants	
TOTAL	

3. Provide evidence that the personnel needed to staff the nursing home will be available.

4. Provide evidence that there will be adequate ancillary and support services to provide the necessary patient services.

5. Provide evidence that indicates the services provided at your facility will be in compliance with applicable federal and state laws, rules, and regulations for health care facilities.

6. Provide evidence that the project will be in compliance with applicable conditions of participation related to the Medicare and Medicaid programs.

7. Fully describe any history of each applicant with respect to the actions noted in the Certificate of Need criterion. (WAC 246-310-230 (5) (a). If there is such a history, provide evidence that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

8. Provide evidence that the project will adequately address continuity of care. Describe the arrangements that will be made with other providers for patient care consultation services. Provide assurance that patients will be referred to a hospital for acute care needed. Also, provide assurance that patients discharged from the nursing home will be referred to home health, hospice, or assisted living agencies when such care is needed.

9. Existing nursing homes will document the number of patients discharged from the nursing home to the patients home, referred to home health, hospice agency, or assisted living services during the last three years.

	19___	19___	19___
# Discharged Home			
# Discharged to Home Health			
# Discharged to Hospice			
# Discharged to Assisted Living Services			

D. COST CONTAINMENT (WAC 246-310-240)

1. Describe distinct alternative means for meeting the need described previously. Identify alternative advantages and disadvantages, including cost, efficiency, or effectiveness.

2. Describe, in as much detail as possible, specific efforts that were undertaken to contain the costs of offering the proposed service.

3. In the case of construction, renovation, or expansion, describe any operating or capital cost reductions achieved by architectural planning, engineering methods, methods of building design and construction, or energy conservation methods used.

4. Under a concurrent or comparative review, preference will be given to the project which meets the greatest number of criteria listed below. Provide documentation describing how the proposed project meets the following criteria.

   a. Projects that include other institutional long-term care services or evidence of relatively greater linkages to community-based, long-term care services.

   b. Projects which improve the geographic distribution and/or provide access to nursing home beds in a currently under-served area.

   c. Nursing home operators having (*or proposing to have*) a Medicare contract in areas with less than the statewide proportion of Medicare nursing home beds to total nursing home beds.

   d. Nursing home operators serving (*or proposing to serve*) Medicaid clients.

   e. Nursing home operators proposing to serve additional heavy care patients in areas where CSO placement staff or hospital discharge planners document significant and continuing difficulties in placing such patients in nursing homes.

   f. Existing nursing home operators in the state who are seeking to achieve a 100-bed minimum efficient operating size for nursing homes or to otherwise upgrade a facility with substantial physical plant waivers or exemptions, as determined by Washington State Aging and Adult Services Administration.

   g. Projects that propose to serve individuals requiring mental health services and care for Alzheimer's or dementia conditions.

INSTRUCTIONS FOR COMPLETION OF COST REPORTING FORMS REQUIRED FOR SUBMISSION OF CERTIFICATE OF NEED APPLICATIONS FOR NURSING HOME PROJECTS

A complete application for a Certificate of Need will include the information requested in the "Application Information Requirements for Health Care Facility Certificate of Need Applications Nursing Home Related Projects." When completed, the enclosed forms will satisfy the information requirements in the Application Information Requirements under B, Financial Feasibility Section III 9(b) i, ii, iii, iv, v, vi, except that an application should list start-up costs separately, and should also identify the anticipated period of deficit operations before the project is utilized at a break-even point.

NOTE: ALL FINANCIAL STATEMENTS MUST BE FOR NURSING HOME OPERATIONS ONLY

"NON-INFLATED" PROJECTIONS

All projections for the first through third years of operation shall be shown in *"non-inflated"* collars based on the last complete fiscal year. Do not show increased costs due to anticipated inflationary trends. These *"non-inflated"* costs should show all anticipated costs resulting from increased staffing, supplies, utilities, etc., and should also show anticipated interest expense and depreciation expense.

EXPLANATION OF COLUMN HEADINGS

"Actual" - These columns apply to existing nursing homes proposing the addition of beds or total replacement of an existing facility. "Actual" must be by fiscal year, in accordance with the way books are kept.

"Estimate" - This column applies to existing nursing homes and shall show estimated operational figures for the current twelve months of operation of the facility.

"Projected" - means each twelve months of operation through at least three full fiscal years following completion of the project.

The dates requested *(directly beneath column headings discussed above)* refer to the actual dates of the fiscal year for historical data, and the anticipated dates for each fiscal year of operation.