NURSING FACILITY

POPULATION BASED APPLICATION

ARKANSAS HEALTH SERVICES PERMIT COMMISSION

ARKANSAS HEALTH SERVICES PERMIT AGENCY
MOSAIC TEMPLARS STATE TEMPLE
906 BROADWAY, SUITE 200
LITTLE ROCK, AR 72201
(501) 661-2509

INSTRUCTIONS FOR COMPLETION OF PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission's Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. **Please review the Commission's adopted nursing facility bed need standards and criteria before starting the application process.**

2. **The Agency recommends that each applicant meet with a staff member of the Health Services Permit Agency (by appointment) for a pre-submission conference.**

3. **Each question must be addressed fully. Contact the staff before a response of "not applicable" is made in order to insure that it is an appropriate response.**

4. **One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.**

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APPLICATION FORM
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Note: POPULATION BASED NEED **Complete this only if your county *has a population based need as shown in the HSPA Bed Need Book***. *This information can be found at www.arhaspa.org.*

A population based need exists when there is a bed need in a county and the occupancy rate for the licensed facilities in that county is at least 80.0% for the most recent available occupancy as reported by DHS.

I. GENERAL INFORMATION

A. Name of Facility: _____

Address: _____

City: _____Zip Code: _____

County: _____ Phone: _____

Fax: _____Email: _____

B. Identification of applicant

Name of Applicant: _____

Corporation/Company _____

Address: _____

City: _____Zip Code: _____

Phone: _____ Fax: _____

Email: _____

C. Application Contact Person: ***(This person will be contacted regarding questions about this application.)***

Name: _____

Title: _____

Corporation/Company _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

D. Project Contact Person: ***(This person will be contacted regarding questions about the project once the POA is issued.)***

Name: _____

Title: _____

Corporation/Company _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

E. Ownership of Facility (Check One):

Individual Owner _____ Corporation _____
Partnership _____
List Names and Addresses of all Owners, Partners and Corporate Officers

_____
_____
_____

Parent Organization: _____

Does this company currently own any Nursing Facility in Arkansas or in another state? Yes _____ No _____

If yes, please list the name and location of each facility?

_____
_____
_____

Do any of the current owners or partners have an interest or ownership in any other Nursing Facility (s) in Arkansas or in another state?
Yes_____ No_____

If yes, please list names of owners / partners and affiliated Nursing Facility (s).

_____
_____
_____

Does applicant currently manage, own or operate any Nursing Facility (s) in Arkansas or in another state? Yes __ No __

If yes, name and location of each facility.

_____
_____
_____
_____

II. POPULATION BASED NEED

*** Net bed need for county _____.**

*** Number of beds requested _____.**

***County occupancy rate for the most recently available occupancy as reported by DHS _____.**

Note: The above information on county bed need and occupancy is available at: http://www.arhspa.org/bed_need/_Bed_Need_Book.pdf

III. PROJECT:

A. General Information

Number of beds proposed _____

Gross square feet to be constructed _____

Proposed per square foot construction cost _____

Estimated Project Cost _____

First year projected annual operating cost: _____

Estimated project initiation date: _____

Estimated project completion date: _____

Has an option been obtained for the site? Yes ____ No _____

- **For new construction, please provide:**
  - **a letter from the Planning Commission stating that the property is properly zoned or that a request for proper zoning has been submitted to the Planning Commission.**
  - **documentation of land ownership or documentation that an option has been obtained for the site.**

B. Project Description

1. **<u>Describe the proposed construction or project.</u>**
   Describe the proposed project, including the services you are planning to provide. (Please do not include details on the type of construction.)

(Example: This is new construction of a 75 bed nursing facility which will have 60 patient rooms, a beauty shop, common dining room, outdoor courtyard, activities room. We will provide 24 hour nursing care.)

******Additional pages may be attached and labeled to correspond to this section. ******

III. COMPLIANCE WITH REVIEW CRITERIA

Note: No application for beds will be approved if the county in which the applicant facility is located had the equivalent of 10% or more of the county's licensed bed capacity approved but unlicensed in the previous fiscal year. E.g. if in 2000 County "A" had 140 licensed beds with a 28 bed approval, then the facilities in County "A" would not be eligible for additional beds under either the Population Based or Utilization Based methodology. The rationale is that an increase in beds would have affected occupancy. This applies to both Population and Utilization based need.

A. UNFAVORABLE REVIEW. Please see Nursing Facility Methodology, Unfavorable Review Section.

B. CRITERIA FOR FAVORABLE REVIEW

1. NEED "Whether the proposed project is needed or projected as necessary to meet the needs of the locale or area."

a. Numeric Need for Population Based Applications is established in the Bed Need Book and documented in Section II of this Application. Please also include demographic analysis that supports the need for the proposed additional beds.

At a minimum, this section should include a narrative description that illustrates the community's need for the proposed nursing home or increased beds in the service area. Supporting data and analysis include the following:

- Population characteristics of the county and targeted service area by age, gender, income, morbidity, functional impairments. You must include a narrative description of the relationship between this demographic data and the population you can expect to enter the proposed nursing facility.
  - Proximity to other facilities including Residential Care, Assisted Living Facilities, Hospitals, or clinics.
  - Current local conditions that favor the occupancy or sustainability of the proposed facility.
  - Local support for the project
  - Transportation access to the facility

- Special needs of this community.
- Special features of this facility.

b. Explain how the proposed project will benefit the community.

2. **STAFFING "**Whether the project can be adequately staffed and operated when completed."

- List by type the number of staff required by DHHS Office of Long Term Care (OLTC) to support this project:

- Explain your plan for recruiting and retaining staff to meet the staffing requirements of OLTC.

- Source of Personnel – detail potential sources of personnel or additional personnel.

3**.** ECONOMIC FEASIBILITY "Whether the proposed project is economically feasible."

4. Cost Containment **"**Whether the project will foster cost containment through improved efficiency and productivity."

- How will the proposed project foster cost containment and save the State money through efficiency and improved productivity?

IV. COST ESTIMATES, FINANCIAL INFORMATION AND BUDGET

A. Financing And Other Cash Requirements

Loans Fees $_____

Bond Issue Cost $_____

Legal Fees, Printing, etc. $_____

Financial Feasibility Study $_____

Consultant Fees $_____

Permits (Building, Utilities, Etc.) $_____

Capitalized Interest During Construction $_____

Debt Service Reserve Fund $_____

Other (Specify) $_____

TOTAL $ _____

B. Physical Plant Costs

Construction Costs $_____

Renovation Cost $_____

Fixed Equipment (not included in construction) $_____

Architect's Fee $_____

Engineering Fees $_____

Contingency Factor (Cost Overrun) $_____

TOTAL $_____

Working Capital Start-up Cost $_____

C. Total Expenses

$_____

D. Please Indicate The Sources of Capital Funds:

Source	Amount	Percent
Tax Credits	$_____	_____
Commercial Loans	$_____	_____
Government Grants and Loans (Please Specify)	$_____	_____
Retained Earnings	$_____	_____
Other Debt Financing	$_____	_____
Other	$_____	_____
TOTAL	$_____	**100%**

E. Supporting Financial Documentation

*You are required to attach original letters of commitment or agreements that indicate the above financing can be obtained***.** All submitted documentation must be signed and dated within 90 days of the application due date**.** Depending on your financing plan in Section D above, you must submit at least one of the following:

1. Pre-approved loan for Total Capital and Working Capital Start-up Cost as evidenced by confirmed loan commitment on bank or lending institution's original letterhead and signature,

2. An audited financial statement showing retained earnings or access to personal funds equal to the amount of the project, signed by an accountant not directly employed by the corporation or a letter verifying the availability of funds equal to the amount needed by the project.

F. What are the terms of debt financing?

1. Rate of Interest _____

2. Term of Debt (years) _____

3. Annual Debt Service _____

4. Total Debt Service _____

G. Total Annual Depreciation cost for facility _____

H. Budget Requirements

1. For new Facilities, a three-year pro forma budget is required as an attachment to the application.

2. For existing facilities, provide the last three years audited income and expense report.

CERTIFICATION

This form completed by: _____

Name Phone

_____

Title

_____

Company/Corporation

_____

Address

_____

City State Zip

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

_____ _____

Date Signature

_____

Title