NURSING FACILITY
APPLICATION FORM

REPLACEMENT FACILITY

(Use this application if you intend to replace an existing facility with new construction).

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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I. General Information

A. Current Facility

Name of Facility: _____

Address: _____

City: _____Zip Code: _____

County: _____ Phone: _____

Fax: _____Email: _____

B. Proposed Facility

Name of Facility: _____

Address: _____

City: _____Zip Code: _____

County: _____ Phone: _____

C. Identification of applicant

Name of Applicant: _____

Address: _____

City: _____Zip Code: _____

Phone: _____ Fax: _____

Email: _____

<u>Application Contact Person</u>: ***(This person will be contacted regarding questions about this application).***

Name: _____

Title: _____
Corporation/Company _____

Address: _____

City: _____Zip Code: _____

Phone: _____Fax: _____

Email: _____

<u>Project Contact Person</u>*: (This person will be contacted regarding the project once the POA is issued).*

_____

Corporation/Company _____

Title: _____ Phone: _____

Fax: _____ Email: _____

Address: _____

City: _____Zip Code: _____

D. Ownership of Facility (Check One):

Individual Owner ____Corporation ___ Partnership ____

List Names and Addresses of all Partners

_____
_____
_____

Parent Organization: _____

Does <u>this company</u> currently own a Nursing Facility(s) in Arkansas or in another state? Yes _____ No _____

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

_____
_____
_____

Do any of the <u>current owners</u> or <u>partners</u> have an interest or ownership in another Nursing Facilities(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 a Nursing Facility(s) in Arkansas or in another state? Yes ___ No ___

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

_____
_____
_____
_____

II. <u>Project Information:</u>

A. Number of beds in current facility: _____

B. Number of beds proposed; (*Replacement facility applicants are eligible for up to a 20% increase of their current licensed capacity)*.
_____

C. Does your facility have any current life threatening compliance?
Yes: _____ No: _____

a. If yes, explain how these issues will be corrected by the proposed construction?

_____
_____
_____

D. Describe the proposed construction or project.

Describe the proposed project, including the services you are planning to provide. (Please do not include details of 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. Construction Information

A. Gross square feet to be constructed: _____

B. Proposed per square foot construction cost: _____

C. First year projected annual operating cost: _____

D. Estimated project initiation date: _____

E. Estimated project completion date: _____

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

G. Has the proposed facility site location been approved by the DHS Office of Long Term Care (OLTC)? Yes _____ No _____

H. For new construction, please attach a letter from the Planning Commission stating that the property is properly zoned.

I. If this application transfers the site location outside of the city limits of the town or city where it is currently located, please attach documentation (copies of letters) indicating that you have notified the Mayor and the County Judge of this proposed move.

IV. Compliance with Review Criteria

Criteria for Favorable Review *(Please read the Nursing Facility Methodology, Section IV. Application Approval Priorities" and Section V. "Unfavorable Review before proceeding with this section).*

A. Need "Whether the proposed project is needed" *(Explain how the proposed project complies with the adopted Replacement Facility standard of need).*

1. **Explain how the proposed project will benefit the community.**

2. **Projected County Need in county of existing facility: _____**

3. **If you are adding beds to the replacement facility, please complete the following section regarding the facility and county from which the beds will be acquired:**

   a. **Name of Facility from which you are acquiring beds. _____.**

      Address _____

      City_____Zip_____County_____

   b. **Current number of licensed beds in this facility: _____**

   c. **Bed Need in this county: _____**

4. **Other expert assessment of need, surveys, or other indications of the need for the proposed project.**

B. Staffing "Whether the project can be adequately staffed and operated when completed."

1. **List by type the number of staff needed for the proposed project.**

2. **Detail potential sources of personnel or additional personnel.**

C. Economic Feasibility "Whether the proposed project is economically feasible"

1. **<u>Cost Estimates for Project:</u>**

Financing and other Cash Requirements

Loans Fees **$_____**

Bond Issue Cost **$_____**

Legal Fees, Printing, etc.	**$_____**
Financial Feasibility Study	**$_____**
Consultant Fees	**$_____**
Capitalized Interest During Construction	**$_____**
Debt Service Reserve Fund	**$_____**
Other (Specify)	**$_____**
TOTAL	**$ _____**

Physical Plant Costs

Construction Costs	**$_____**
Architect's Fee	**$_____**
Engineering Fees	**$_____**
Contingency Factor (Cost Overrun)	**$ _____**
TOTAL	**$_____**
Working Capital Start-up Cost	**$_____**
TOTAL EXPENSES	**$_____**

2. **Sources of capital funds:** *You are required to attach original letters of commitment or agreements that indicate the financing has been committed to this project. All submitted documentation must be signed and dated within 90 days of the application due date. Depending on your financing plan below, you must submit one of the following:*

    - Pre-approved loan for Total Capital and Working Capital Start-up Cost as evidence by a confirmed loan commitment on bank / lending institution's original letterhead with signature.

    - Audited financial statement showing retained earnings equal to the amount of the project with signature by an accountant not directly employed by the corporation.

- A proof of bank deposit for the total amount of the project on a bank's letterhead signed by a bank officer.

Source	**Amount**	**Percent**
Commercial Loans	**$**_____	_____
Government Grants and Loans (Please Specify)	**$**_____	_____
Bond Issue	**$** _____	_____
Fund Drive	**$** _____	_____
Retained Earnings	**$**_____	_____
Other Debt Financing	**$**_____	_____
Other	**$**_____	_____
TOTAL	**$**_____	**100%**

3. **Terms of Debt Financing**

Rate of Interest _____

Term of Debt (years) _____

Annual Debt Service _____

Total Debt Service _____

Total Annual Depreciation cost for facility _____

4. **Budget Requirements**

- Please attach a three –year pro-forma budget.
- For existing facilities, please provide the last three years audited income and expense report.

D. COST CONTAINMENT "Whether the project will foster cost containment through improved efficiency and productivity."

Describe how will the proposed project will foster cost containment and save the state money through efficiency and improved productivity.

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