NURSING FACILITY
UTILIZATION BASED APPLICATION FORM

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 home bed need standards and criteria and HSC Regulation 100M Nursing Facility Bed Methodology before beginning 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) copies 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.**

NURSING FACILITY
APPLICATION FORM
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UTILIZATION BASED (Complete this section only if your county does not show a population based need.) A utilization-based application is for counties without a population-based need. The applicant facility must have averaged 90% occupancy for the previous 12-month period as documented by DHS, have no approved but unlicensed beds currently or in the previous 12-month period. The county must not have 10% or more of its licensed bed capacity approved but unlicensed in the previous 12-month period.

- **GENERAL INFORMATION**

A. Identification of applicant

Name of Applicant: _____

Corporation/Company _____

Address: _____

City: _____Zip Code: _____

Phone: _____ Fax: _____

Email: _____

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

Name: _____

Title: _____

Corporation/Company _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

C. 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: _____

D. Ownership of Facility (Check One):

Individual Owner _____ Corporation _____
Partnership _____

List Names and Addresses of all Partners
_____
_____
_____

Parent Organization: _____

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

If yes, what is the name, and location of each Facility?
_____
_____
_____

Do any of the <u>current owners or partners</u> 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. Explain how the proposed project complies with the adopted Utilization Based standard of need. *Information can found at* ***www.arhspa.org/bed-need.html***

A. Name and address (including County) of the facility from which you are acquiring beds.

Name of Facility: _____
Address: _____
City: _____ Zip: _____ County: _____

B. **Applicant facility's occupancy rate for the previous 12-month period = _____ (***Must be at least 90% to qualify for Utilization Based beds.)*

C. **Applicant's number of approved but unlicensed beds in the previous 12-month period = _____. (***If response is > 1, ineligible for Utilization Based beds).*

D. Net bed need for the applicant's county = _____.

E. Number of licensed beds in the county = _____.

F. Number of approved but unlicensed beds in the applicant's county in the previous State fiscal year = _____.

G. Divide Item "E" by Item "F"; if > 10%, then county is not eligible for additional beds.

H. Answer the following question only if you are acquiring beds from a facility in a county other than the one for which you are applying.

a. Occupancy rate of the facility from which you are acquiring beds for the previous 12-month period = (Must be <70%). _____.

III. Project:

A. General Information

1. Number of additional beds proposed _____

2. Gross square feet to be constructed _____

3. Proposed per square foot construction cost _____

4. Estimated Project Cost _____

5. Estimated project initiation date: _____

B. Estimated project completion date: _____

C. Project Description

Describe the proposed construction or renovation for this project.

Describe the proposed project, including any expanded **services you are planning to provide. (Please do not include details of the type of construction.)**

(Example: *This is an addition of 10 beds to an existing 75 bed nursing facility for a total of 85 patient beds. Facility already has 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. ******

IV. COMPLIANCE WITH REVIEW CRITERIA

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

B. CRITERIA FOR FAVORABLE REVIEW

1. NEED "Whether the proposed project is needed"

a. Please submit a market feasibility study.
At a minimum, the feasibility study should include a narrative description with supporting data and analysis that illustrates the need for the proposed increased number of beds in the service area. Data and analysis should also be included for the following:

- **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 increase.**
- **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.

C. STAFFING "Whether the proposed increase 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 increase:**

- **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.**

D. ECONOMIC FEASIBILITY "Whether the proposed project is economically feasible"

1. **Cost Estimates for Project (If this application is for a cost overrun, please put the new cost amounts here.**

E. 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?

V. Budget and Financing

A. Cost Estimates for Project

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	**$_____**
Working Capital Start-up Cost	**$_____**
TOTAL EXPENSES	**$_____**

C. 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%**

D. You are required to attach <u>original</u> 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 C above, you must submit at least one of the following

1. **Pre-approved loan for Total Capital and Working Capital Start-up Cost.**

2. **An audited financial statement showing retained earnings equal to the amount of the project, signed by an accountant not directly employed by the corporation.**

E. What are the terms of debt financing?

1. **Rate of Interest** _____
2. **Term of Debt (years)** _____
3. **Annual Debt Service** _____
4. **Total Debt Service** _____

- **Total Annual Depreciation cost for facility _____**

F. 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: _____ Title; _____

_____
Company/Corporation

_____
Address

_____
City State Zip

Phone: _____; Fax _____

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

_____ _____
Date Signature