

COMMONWEALTH OF VIRGINIA

APPLICATION

FOR A MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED

(Chapter 4, Article 1:1 Of Title 32.1,

Sections 32.1-102.1 through 32.1-102.12

The Code of Virginia (1950), as amended)

LONG-TERM CARE FACILITIES

NOTE: The complete set of application materials includes the Instructions and four other attachments listed on page 45.

revised October, 1997 (corrected copy)

SECTION I

FACILITY ORGANIZATION AND IDENTIFICATION

A. _____
Official name of the facility where this project will be located

Physical address (and mailing address, if different) of facility where this project will be located

City State ZIP

Telephone

B. _____
Legal name of the applicant

Name and title of the applicant's chief administrative officer

Mailing address of the applicant's chief administrative officer

Telephone

C. _____
Name and title of the person to whom questions regarding this application should be addressed

Mailing address of the contact person for this application

Telephone

Fax no.

D. Information About the Applicant.

1. List all organizations of which the applicant is a wholly or partially owned subsidiary.
2. Provide the names and locations and identify the principal activity (e.g., nursing home, ambulatory surgery center, etc.) of all health care facilities owned or operated by the applicant in Virginia. Indicate which facilities are owned but not operated by the applicant, which are operated but not owned, and which are both owned and operated by the applicant.
3. Will the applicant be the *owner* of the facility covered by this application? Yes No.
If not, give the legal name and address of the owner and state the relationship of the applicant to the owner.
4. Will the applicant be the *operator* of the facility covered by this application? Yes No.
If not, give the legal name and address of the operator and state the relationship of the applicant to the operator.

E. Type of Owner and Operator of the Proposed Nursing Home. Complete Table I-E below and provide the requested documentation for *both* the owner and operator of the proposed nursing home:

Table I-E

Type of Owner and Operator of the Proposed Nursing Home

Type of Control	Owner <i>(place the name of the owner in the appropriate block)</i>	Operator <i>(place the name of the operator in the appropriate block)</i>	Documentation to Attach for Owner/Operator of This Type
Proprietary			
Individual (sole proprietor)			
Partnership			partnership agreement, evidence of recordation
Limited liability company			articles of incorporation, certificate of incorporation
Subchapter S corporation			articles of incorporation, certificate of incorporation
Subchapter C corporation			articles of incorporation, certificate of incorporation
Other (identify)			governance document, registration with state authorities
Non-Profit			
Corporation			articles of incorporation, certificate of incorporation
Other (identify)			governance document, registration with state authorities
Governmental			
State			
County or city			
Special purpose authority/commission			charter
Other (identify: _____)			charter or governance document

F. Ownership of the Site. (Check one, fill in the blank, and **attach a copy of the relevant document.**)

1. _____ Fee simple title held by the applicant or the owner of the proposed nursing home.
2. _____ Option to purchase held by the applicant or the owner of the proposed nursing home.
3. _____ Leasehold interest for not less than _____ years held by the applicant or the operator.
4. _____ Renewable lease, renewable every _____ years held by the applicant or the operator.
5. _____ Other (identify: _____).

G. Information About the Owners of the Proposed Nursing Home.

1. Provide the following documents according to the type of ownership of the proposed nursing home:

Ownership of Nursing Home	Documents to Be Attached
Partnership	Name, address of each partner/member/stockholder
Limited liability company	Name, address of general or managing partner or administrative member
Subchapter S corporation	
Subchapter C corporation	Name, address of each member of board of directors Name, title of each officer Name, address of the registered agent Name, address of any person holding five percent or more of the voting stock
Non-profit corporation	Name, address of each member of board of directors Name, title of each officer Name, address of the registered agent
Any other type of owner	Name, address of each member of governing body Name, title of each officer

2. If the proposed nursing home will be owned by a sole proprietor, a partnership, a limited liability company, or a subchapter S corporation, provide the information indicated in the table below for each person having *any* ownership interest in the proposed nursing home.

If the proposed nursing home will be owned by a subchapter C corporation, provide the information indicated in the table below for each person owning or having beneficial ownership of *five percent or more* of the voting stock of the corporation.

Ownership of Proposed Nursing Home	Persons for Whom Information to Be Reported	Other Nursing Homes to Be Identified	Information to Be Reported for Each Identified Other Nursing Home
Sole proprietor Partnership Limited liability company Subchapter S corporation	Each person with <i>any</i> ownership interest in the proposed nursing home	Every other nursing home in the U.S. in which the person has <i>any</i> ownership interest, <i>other than as a stockholder of a publicly traded corporation</i> which owns the nursing home	Name and address of the nursing home Nature and extent of the person's ownership (e.g., 10% partner, 20% stock in an LLC, etc.) Whether and in what form the person exercises any direct management responsibility (e.g., managing partner, facility administrator, etc.)
Subchapter C corporation	Each person owning <i>five percent or more</i> of the voting stock	Every other nursing home in the U.S. in which the person has <i>any</i> ownership interest, <i>other than as a stockholder of a publicly traded corporation</i> which owns the nursing home	Name and address of the nursing home Nature and extent of the person's ownership (e.g., 10% partner, 20% stock in an LLC, etc.) Whether and in what form the person exercises any direct management responsibility (e.g., managing partner, facility administrator, etc.)

H. Information About a Non-Owner Operator. If the owner of the proposed nursing home will *not* be the operator, provide the following information pertaining to the operator:

1. Name and address of the registered agent (for a subchapter C corporate operator).
2. Name and address of the general or managing partner (for a partnership or subchapter S corporate operator).
3. Name and address of the administrative member (for a limited liability company).
4. If the project would be part of an *existing* facility, an executed copy of the contract or agreement between the owner and the operator of the existing facility.
5. If the application is for a *new* nursing home, a copy of the proposed contract or agreement between the owner and expected operator, and a statement from each party that they are willing to execute the proposed contract, if the project is implemented.

SECTION II**ARCHITECTURE AND DESIGN****A. Location of the Proposed Project and Description of Project Site.**

1. Physical address including ZIP code: _____
2. Directions to the project site, if the physical address is not an established street address:

3. Located in: county/independent city _____
Planning District _____
4. Size of the site: _____ acres.

B. Land-Use Controls and Construction Approvals.

1. Flood Protection Requirements. Is the site within a 100-year flood zone, as delineated on the most recent flood zone map published by the U.S. Federal Emergency Management Agency? If so:
 - a. Is the site within the "floodway" or within the "flood fringe area"?
 - b. What special requirements must be met and what special administrative steps must be taken to obtain a building permit for construction on this site in the flood zone?
 - c. What design features (e.g., roadway elevation, minimum floor elevation, floodproofing, etc.) will be incorporated into the facility and into site improvements to provide protection from floods and meet the requirements for a building permit for this site in the flood zone?
 - d. Will flood insurance be obtained to cover this project?
 - e. Will this location in the flood zone affect the availability or terms of financing for the project? If so, describe how the financing will be affected.
2. Zoning and Use Permits. Provide appropriate documentation (for example, copies of local ordinances, zoning map, letters from appropriate local government office) of the following:
 - a. What is the current zoning of the proposed site? Does this zoning classification permit operation of a nursing home?
 - b. If the current zoning does not permit operation of a nursing home, what is the process for obtaining rezoning or a zoning variance? What is the status of efforts to obtain the necessary zoning approval?
 - c. Is a use permit also required to operate a nursing home? If so, has a use permit been obtained? If a use permit is required and has *not* been obtained, what is the process for obtaining the necessary use permit, and what is the status of efforts to obtain it?

C. Type of Project for Which a Certificate of Need is Requested (check all applicable).

1. _____ Construction of a new facility.
2. _____ Addition to an existing facility by new construction.
3. _____ Remodeling/renovation of an existing facility (not involving an addition).
4. _____ No new construction or remodeling/modernization.
5. _____ Other (identify: _____).

D. Design of the Facility.

1. Is there a long-range plan that covers the facility? If yes, attach a copy or identify the plan document and provide a brief summary of it, which describes expected future development and patient care activities at the facility. Explain the relationship of the proposed project to the long-range plan.
2. Briefly describe the style and major design features of the proposed project. Note in particular any features which will make the project less expensive to construct or operate or will allow the proposed nursing home to better serve the needs of residents.
3. Describe the location of the facility and its access to public transportation and principal highways.
4. If the application proposes to replace an existing facility, what use will be made of the existing facility after the new facility is completed?

E. Utilities.

1. Describe how the facility will be provided with water supply, wastewater treatment/disposal, solid waste removal, and energy services.
2. State the principal energy source(s) to be used to heat and cool the facility.
3. Document the status of arrangements to obtain each type of utility service. Documentation should include the following:
 - a. Letters from appropriate governmental agencies verifying the availability and adequacy of public water supply and public wastewater treatment/disposal services for the facility or receipts for water and sewer connection fees.
 - b. If septic tanks are planned to be used, evidence that the site is suitable for their installation.
 - c. If an on-site or other private wastewater treatment/disposal plant is to be used, description of this facility and the status of arrangements to obtain the necessary permits for its use.
 - d. Letter from appropriate governmental agency or commercial firm verifying the availability of adequate solid waste removal services.
 - e. Letter(s) from local energy utility(ies) verifying the availability of adequate energy services.

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- F. Space Tabulation. Provide a space tabulation, using the format of Table II-F, "Tabulation of Space by Functional Areas" (attached to this application form). Complete all columns of Table II-F that apply to this project, and complete the final column ("Total Square Feet After Completion of Project"). In addition, state the number of square feet in *each type* of existing or new *patient room* in the nursing home covered by this application. The information provided here should be consistent with any preliminary drawings.
- G. Site Plan. Attach a plot plan of the site which includes at least the following:
1. The courses and distances of the property line.
 2. Dimensions and location of any buildings, structures, roads, parking areas, walkways, easements, rights-of-way, or encroachments on the site.
- H. Preliminary Design Drawing. Attach a preliminary design drawing, drawn to a scale of not less than 1/16 in. = 1 foot, showing the functional layout of the proposed project, which indicates at least the following:
1. The layout of each typical functional unit.
 2. The spatial relationship of separate functional components to each other.
 3. Circulatory spaces (halls, stair wells, elevators, etc.) and mechanical spaces.
- I. Expected Development Schedule (provide expected date or actual past date, as applicable).
1. Ownership or control of site obtained _____
 2. Zoning and any other required land-use approvals obtained _____
 3. Submission of architectural and working drawings to Department of Health and State Fire Marshal _____
 4. Construction financing obtained (i.e., arranged, not necessarily disbursed) _____
 5. Long-term financing obtained (i.e., arranged, not necessarily disbursed) _____
 6. Pre-construction site work initiated _____
 7. Construction contract awarded _____
 8. Construction initiated _____
 9. Construction completed _____
 10. Patient service begins _____

SECTION III**SERVICE DATA**

- A. **Description of Services.** Use this section to provide a brief narrative description of the services to be provided after completion of the project. Provide *only a description* of the services, leaving the justification and explanation of need for section IV of the application.
1. **New Facility.** If this application proposes establishment of a new long-term care facility, describe the kind of patient care services proposed to be available after completion of the project. Briefly note the full range of patient care services to be provided, and note in particular any specialized or comparatively uncommon services that tend to differentiate this project from most long-term care facilities.
 2. **Addition to an Existing Facility.** Describe the kind of patient care services now available in the existing facility. Briefly note the full range of patient care services provided, and note in particular any specialized or comparatively uncommon services that tend to differentiate the existing facility from most long-term care facilities. Describe how the proposed addition will support, change, or expand the patient care services now provided in the existing facility.
 3. **Remodeling/Renovation of an Existing Facility (not involving an addition).** Describe the kind of patient care services now available in the facility. Briefly note the full range of patient care services provided, and note in particular any specialized or comparatively uncommon services that tend to differentiate the existing facility from most long-term care facilities. Describe how the proposed remodeling/renovation will support, change, or expand the patient care services now provided in the facility.
 4. **No New Construction or Remodeling, Other Applications.** Describe the kind of patient care services now available in the facility. Briefly note the full range of patient care services provided, and note in particular any specialized or comparatively uncommon services that tend to differentiate the existing facility from most long-term care facilities. Describe how the proposed project will support, change, or expand the patient care services now provided in the facility.
- B. **Bed Complement and Utilization.**
1. Complete the attached Table III-B to provide data on projected bed capacity and utilization, by type of unit, for the first two full years of operation following completion of the project. If the application involves an existing long-term care facility, provide data on actual bed capacity and utilization for the past three years. Be sure to use the same annual periods and show the same nursing home patient days in Table III-B as are used for the revenue and expense data presented in section V.F, "Long-Term Care Actual and Estimated Revenue and Expense Statement."
 2. Explain the methodology, including key assumptions, used to develop the utilization projections for the future years shown in Table III-B. referenced above.
- C. **Staffing of Existing and/or Proposed Facility.** Complete Table III-C (attached to this application form) to provide staffing information for the proposed facility and for any existing long-term care facility involved in this application. If the proposed or existing facility includes adult care residence beds, provide staffing information for the ACR beds as well as for the nursing home beds.

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1. For each job title with current or projected *employed* personnel, enter the current or projected *average annual salary* for one full-time-equivalent (FTE) employee. For each job title with current or projected *consultant* personnel, provide the current or projected *hourly consultant fee*.
 2. For each job title, show the total number of FTE personnel (i.e., 2,080 hours per year) currently employed and projected to be employed by the facility (in the second year after completion). For facilities that use a 7.5-hour work day for nursing staff, use 1,950 hours to calculate FTEs, and note that this is the definition of nursing staff FTEs that was used. For each job title, show the number of consultant hours for which the facility currently pays and projects to pay (in the second year after completion).
 3. Do *not* report contract hours for services which are *not paid for* by the facility, even though contracted by the facility. Such services include those billed directly to the resident, for example dental services or the services of a personal physician.
 4. Provide job titles and the other requested information for any positions which currently exist or are projected to exist, but which are not specifically identified on Table III-C.
 5. Applicants operating or proposing to develop specialized care units must include additional lines in Table III-C so as to *clearly and separately identify* the personnel assigned to the specialized care units. Specialized care units are not limited to those services recognized as specialized care by the Virginia Department of Medical Assistance Services. A specialized care unit may be any type of unit operated to provide a specialty service or house a specific population of residents requiring services distinct to their condition.
 6. The number of FTEs shown for each job title on Table III-C, multiplied by the average annual compensation for that job, should yield the personnel expenditures shown in section V. If not explain why not, and describe how the personnel expenses in section V were calculated.
- D. Nursing Personnel By Shift. Complete Table III-D below to show the number of nursing personnel projected to be working on each shift in the proposed nursing home and adult care residence units per typical 24-hour day in the *second year* of operation following completion of the project. Do not include the director of nursing or any other nursing personnel who will *not* provide direct patient care. Please explain if there are any days, such as weekend days, for which the data in Table III-D usually would not apply.

Table III-D

Nursing Personnel by Shift
(nursing home and ACR units)

Job Title	Shift						Total Persons for Day		Total Hours per Day		Total Hours per Year	
	Day		Evening		Night		NH	ACR	NH	ACR	NH	ACR
	NH	ACR	NH	ACR	NH	ACR						
Registered nurses												
Lic. practical nurses												
Certif. nurse assist.												
Total												

E. Nursing Hours per Patient Day. Fill in each of the following blanks (with respect to nursing home units only), based on data projected for the *second* year following completion of the project:

1. Total nursing hours worked in Year 2 (nursing home only) from Table III-D _____.
2. Total nursing home patient days in Year 2 from Table III-B _____.
3. Nursing hours per patient day in Year 2 - total nursing hours divided by total patient days _____.

F. Key Nursing Home Personnel Hired in Last Two Years. If the application involves an existing nursing home, identify the number of *new* incumbents in each of the following positions at the nursing home in the last two years:

1. Administrator _____.
2. Director of nursing _____.
3. Registered nurses _____.
4. Department heads _____.

G. Recruitment and Retention of Personnel. Present a plan for obtaining and retaining the personnel required to staff the project following completion. Describe the results of any efforts to date to determine the potential sources and availability of required personnel.

Provide documentation from any physicians who have expressed a willingness to serve as medical director of the facility upon completion of the project (which may include documentation from the present medical director, if an existing facility is involved).

H. Training Opportunities for Staff. Describe any recent, current, or proposed formal training programs for nursing home staff, especially nursing staff, conducted, sponsored, or financed by the applicant.

SECTION IV**PROJECT EXPLANATION, JUSTIFICATION, AND
CONSISTENCY WITH STATE AND REGIONAL PLANS**A. Explanation of Project.

1. Comprehensive Narrative Summary. Provide a comprehensive narrative *summary* of the proposed project. This summary description should draw together the most important points of information set forth in more detail elsewhere in the application. Points to be summarized here might include such matters as:

- Whether this is a new facility or a replacement, expansion, or remodeling of an existing facility.
- Location of the project.
- Size of the project.
- Time frame for development and expected date of occupancy.
- Projected development costs.
- Method of financing.
- Significant design features.
- Type of services to be offered.
- Population and area to be served.
- Expected distribution of residents by principal source of payment.
- Any special relationship with any existing or proposed health care facility.
- Any other factors or characteristics that may make this project different from or superior to other existing or proposed long-term care facilities in the area.

2. Geographic Origin and Condition of Residents.

- a. Identify the geographic boundaries of the proposed nursing home's primary service area, the area in which at least a majority of the nursing home's residents are expected to reside before being admitted to the nursing home. Estimate the proportion of residents, at two years after completion, expected to come from each county and independent city within the proposed primary service area. Identify other areas, outside the proposed primary service area, from which the nursing home expects to draw significant numbers of residents and estimate the proportion of residents to come from these areas. Provide data in the format of Table IV-A below. Include out-of-state areas, if they are part of the facility's expected primary service area.

Describe the basis for determining the primary and other service areas (such as patient origin data for an existing nursing home, a market survey for a new nursing home, or other information regarding existing medical service travel patterns in the area). If the proposed nursing home is expected to draw residents from an unusually wide area or from an area with an unusual configuration, explain the reasons for this.

- b. If the application involves an existing nursing home, provide a tabulation of the following data for residents *presently in the nursing home*:
- (1) Patient origin (ZIP code and county/city of residence before admission), using the format of Table IV-A below.
 - (2) Principal diagnosis relating to admission to the nursing home.
 - (3) Patient intensity (PIRS) classification of Medicaid patients.

Table IV-A

Geographic Origin of Nursing Home Residents Prior to Admission

County/Independent City and ZIP Code*	Current Number of Residents (if existing nursing home involved)	Percent of Total Current Residents	Expected Number of Residents at Two Years After Completion	Percent of Total Residents at Two Years
Proposed Primary Service Area (PSA)				
County "A"				
ZIP Code*				
ZIP Code*				
<i>show each individual county "A" ZIP code* with 5 or more</i>				
<i>show sum of all other county "A" ZIP codes* with 4 or less</i>				
<i>Total - County "A"</i>				
<i>repeat as above for every other county/city in PSA</i>				
<i>Total - Primary Service Area</i>				
Outside Proposed Primary Service Area (OPSA)				
County "D" (as a whole, not by ZIP)				
City "E" (as a whole, not by ZIP)				
<i>show each OPSA county/city with 5 or more</i>				
<i>show sum of all other OPSA counties/cities with 4 or less</i>				
<i>Total - Outside Primary Service Area</i>				
Total - All Areas		100%		100%

*If a ZIP code area crosses city or county boundaries, all residents originating from that ZIP code may be classified as coming from the particular city or county in which the majority of the ZIP code population is believed to reside.

3. Attachments Requested. Attach a map covering the proposed service area and appropriate adjacent areas, annotated to show the following (including out-of-state areas, as appropriate):
 - a. Location of the proposed project.
 - b. Identification of the proposed primary service area and other areas from which significant numbers of residents are expected to be drawn by this project.
 - c. Location of all other *inpatient* medical care facilities, by name and type (e.g., acute-care hospital, rehabilitation hospital, psychiatric hospital, nursing home, etc.) within or near the proposed primary service area of this project.
 - d. Location of any *outpatient* medical care facility of *likely relevance* to this project, by name and type (e.g., diagnostic center, physicians office building, etc.).

B. Justification of Project.

1. List by name, location, and bed capacity all other facilities in the planning district and all facilities outside the planning district but within 45 minutes driving time of the project site that offer long-term care services generally similar to those proposed to be offered by this nursing home. If any *apparently* similar facility within the specified area is judged in fact *not* to offer similar services,

explain the reasons for this conclusion. Identify any facility within the specified area that offers any specialized service, as defined by the applicant, which this project also proposes to offer.

2. Describe the extent, if any, to which this project will result in improved geographic accessibility of long-term care services within the proposed nursing home's identified service area. *(The response to this item may be combined with the response to "Accessibility" standard A, "Travel Time", below.)*
3. Describe in sufficient detail for the reviewer to understand any ways in which the services of the proposed nursing home will be different from or superior to the services of similar facilities within the planning district or outside the planning district but within 45 minutes driving time of the project site.

Points of differentiation might include the availability of care for particular resident conditions, the availability of specialized resident units and staff with special training, characteristics of the physical plant, availability of beds to serve residents with particular sources of payment, or any other matter the applicant believes distinguishes the proposed nursing home from existing similar facilities.

4. Discuss whether and to what extent existing facilities within the planning district and outside the planning district but within 45 minutes driving time of the project site are believed *not* to meet the demand for services of the type to be offered by this nursing home: Describe the methods and assumptions used to determine the need for any particular service orientation or specialized services this nursing home proposes to offer.
 - a. Currently.
 - b. In five years.

- C. Consistency of the Application with the State Medical Facilities Plan (SMFP). Address each of the following standards (shown in boldface type below) from the State Medical Facilities Plan: Nursing Home Services, 12 VAC 5-360. If a standard is not applicable to this project, state the reason the standard is not applicable. Clear, specific responses to the SMFP standards, supported by relevant documentation, will contribute to the efficiency and accuracy of the review process. *In particular, address fully and specifically the extent to which the application qualifies for any "preference" offered under any of the following standards from the SMFP.* Note also the specific instructions or suggestions below for responding to several of the standards.

SMFP Standards - Acceptability:

- A. **Consumer Participation.** Providers of nursing home services should have written policies and procedures, regarding the treatment of residents and the management of resident care, which are available to residents and their families.
- B. **Consumer Satisfaction.** Providers of nursing home services should have established mechanisms for evaluating resident and resident family satisfaction with the services they provide. Preference will be given in the review of competing applications to providers who can demonstrate high levels of resident and resident family satisfaction with their services through their active and on-going evaluation process.

SMFP Standards - Accessibility:

- A. Travel Time.** Nursing home beds should be accessible within a 45-minute driving time, under normal conditions, to 90 percent of all Virginians. Preference will be given in the review of competing applications to proposed nursing home facilities which substantively improve geographic access and reduce travel time to nursing home services within a planning district.

The response to this item may be combined with the response to item B.2 above.

- B. Access to Highway System.** Nursing home services should be linked by paved roads to a state or federal highway and should be accessible by public transportation, when such systems exist in an area. In urban areas, preference will be given in the review of competing applications to proposed nursing facilities which are fully accessible by private and public modes of transportation.
- C. Financial.** Nursing home services should be accessible to all persons in need of such services without regard to their ability to pay or the payment source. Preference will be given in the review of competing applications to proposed nursing facilities which will be accessible to all persons in need of such services without regard to their ability to pay or the payment source and can demonstrate a record of such accessibility.
- D. Distribution of Beds.** Preference will be given in the review of competing applications to proposals which correct any maldistribution of beds within a planning district.

The applicant is invited to provide an analysis comparing the present distribution of nursing home beds in the planning district and relevant adjacent areas to the distribution of population, especially the population most likely to require nursing home services, and to show how this project would improve the present distribution of beds.

SMFP Standards - Availability:

- A. Need for Additional Nursing Home Beds.**

The application does not need to address this standard.

- B. Expansion of Existing Nursing Facilities.** Proposals for the expansion of existing nursing facilities should not be approved unless the facility has operated for at least three years, and average annual occupancy of the facility's existing beds was at least 95% in the most recent year for which bed utilization has been reported to the Department.

Exceptions to this standard will be considered for facilities that have operated at less than 95% average annual occupancy in the most recent year for which bed utilization has been reported to the Department, when the facility can demonstrate that it has a rehabilitation or other specialized care focus which results in a relatively short average length of stay and, consequently, cannot achieve an average annual occupancy rate of 95%.

To address appropriately this element of the standard, the application should provide such information as:

- Number of discharges during the last twelve months.
- Average length of stay or distribution of lengths of stay for residents discharged during the last twelve months.
- Principal diagnosis or reason for admission to the nursing home for those residents discharged during the last twelve months.
- Description of the kind and volume of therapeutic services provided by the nursing home during the last twelve months that would constitute a rehabilitation or other specialized care focus.

Preference will be given in the review of competing applications to proposals which involve the expansion of free-standing nursing home facilities of 60 or fewer beds, when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.

In a case where no competing applicant is a freestanding nursing home facility with 60 or fewer beds, or where freestanding nursing homes of 60 or fewer and 61 to 90 beds are competing, preference will also be given in the review of competing applications to proposals which involve the expansion of freestanding nursing home facilities of 90 or fewer beds, when such facilities can demonstrate substantial compliance with the standards of the State Medical Facilities Plan.

C. Bed Need Forecasting Method.

The application does not need to address this standard.

D. Minimum Size of New Nursing Home Facilities. No new freestanding nursing home facilities of less than 120 beds should be authorized. Consideration will be given to the authorization of new freestanding facilities with fewer than 120 nursing home beds, when these beds are combined with adult care residence facilities.

E. (To be addressed only by applications from CCRCs) Continuing Care Retirement Communities. Proposals for the development of new nursing home facilities or the expansion of existing facilities by continuing care retirement communities will be considered in accordance with the following standards:

- 1. The total number of new or additional beds plus any existing nursing home facility beds operated by the continuing care provider does not exceed 20% of the continuing care provider's total existing or planned independent living and adult care residence population.**

To address appropriately this element of the standard, the application should provide estimates for a specified future date of the expected population of the planned independent living and adult care residence units, by type and size of unit. The application should specifically describe the basis for these estimates, such as the applicant's experience at existing facilities or research provided by an actuary or other qualified consultant.

- 2. The proposed beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of section 38.2-4905 of the Code of Virginia.**

3. The applicant agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act.
4. The applicant agrees in writing to obtain, prior to admission of every resident of the continuing care retirement community, the resident's written acknowledgment that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit.
5. The applicant agrees in writing that only continuing care contract holders who have resided in the continuing care retirement community as independent living residents or adult care residents and are holders of standard continuing care contracts will be admitted to the nursing home facility after the first three years of operation.

SMFP Standards - Continuity:

- A. **Coordination of Services.** Nursing home facilities should have written agreements with acute care hospitals for the transfer of residents in need of acute medical services and should be located within reasonable access to acute care facilities.
- B. **Emergency Medical Care.** Emergency medical services should be within a 15-minute response time of a nursing home facility, under normal conditions.
- C. **Care Continuum.** Preference will be given in the review of competing applications to projects which provide multiple levels of long-term care and can demonstrate that they function effectively as a continuum of care which optimizes the match between resident needs and the facilities and services provided.
- D. **Family Support.** Nursing home facilities should provide services, such as adult day care services and respite care programs, and engage in activities, such as care-giver education, care-giver support groups, and referral programs, which support the ability of families to provide long-term care to their family members within the home. Preference will be given in the review of competing applications to project applicants who can demonstrate a history or commitment to the provision of services and activities which support the ability of families to provide long-term care to their family members within the home.
- E. **Noninstitutional Service Support.** Nursing home facilities should facilitate the use of noninstitutional long-term care services whenever such services are an appropriate alternative for persons in need of long-term care. Preference will be given in the review of competing applications to project applicants who can demonstrate a history of or commitment to investing in non-institutional long-term care services in their communities.

SMFP Standards - Costs:

- A. Development Costs.** The direct construction cost of proposed nursing facilities should be within the construction cost index cap used by the Department of Medical Assistance Services or be comparable with the recently observed cost for similar facilities in the same health planning region. Other development costs of proposed nursing facilities should be comparable with the recently observed costs for similar facilities in the same health planning region. Preference will be given in the review of competing applications to proposals which have lower development costs than their competitors and can demonstrate that their cost estimates are credible.

The application should address the credibility of the estimates of construction and other development costs for the proposed project. This could be done, for example, by showing that the applicant has developed other, similar nursing homes at development costs comparable to those estimated for this project, after adjusting for inflation and any documentable geographic cost differences. The credibility of the cost estimates could also be addressed by describing the process by which the estimates were developed and by offering statements from architects/engineers which support the credibility of the cost estimates.

- B. Consideration will be given to the experience of applicants in completing similar projects on time and within the authorized capital costs.** Preference will be given in the review of competing applications to applicants who have a good record of performance in completing projects on time and within the authorized capital costs.

The application should describe and document the applicant's experience and history of performance that are relevant to this standard. Although experience with directly comparable projects in Virginia would best address this standard, experience with other kinds of projects and experience outside Virginia will also be considered.

- C. Operating Costs and Charges.** The operating costs and charges of nursing home facilities should be comparable with those of nursing home facilities operating in the same health planning region that provide similar staffing levels and a similar range of services. Preference will be given in the review of competing applications to applicants who can reasonably project lower operating costs and charges than their competitors at staffing levels appropriate to their intended level of care.

The application should address the credibility of the estimates of operating costs and charges for the proposed project. This could be done, for example, by showing that the applicant has other, similar nursing homes, especially ones in Virginia, with operating costs and charges comparable to those estimated for this project, after adjusting for any documentable geographic cost differences. The credibility of the cost and charge estimates could also be addressed by describing how the estimates were developed or by offering statements from external accountants that support the credibility of the estimates. All expenses and expense comparisons should be expressed in *current* prices and should *not* be inflated forward to the expected time of project completion or any other future time. However, all charges and charge comparisons should be expressed at the levels expected to apply when this project is complete and ready to offer patient services.

Proponents of the replacement and relocation of nursing home facility beds should reasonably demonstrate that the replacement and relocation will allow for comparable operating costs and charges over the life of the replacement facility as compared to continued operation of the existing facility.

The application should provide a specific and detailed comparison of the actual current expenses of the existing nursing home with the projected expenses (using *current* prices) of the proposed replacement nursing home. The comparison should specifically identify any materially *increased* expenses associated with the new nursing home, for example increased depreciation and interest expenses, and should specifically identify any materially *reduced* expenses associated with the new nursing home, for example reduced utility and maintenance expenses. (In other appropriate sections, the application should also describe any *non-financial* benefits associated with the replacement nursing home, especially features of the new nursing home that will improve patient care services or improve the living environment for residents.)

SMFP Standards - Quality:

- A. Licensure and Accreditation.** Nursing home facilities should be maintained and operated in compliance with all applicable state licensure regulations. Preference will be given in the review of competing applications to applicants who can demonstrate a consistent history of compliance with state licensure regulations.

The response to item B below can serve also as the response to this item.

Nursing home facilities should be accredited by the Joint Commission on Accreditation of Healthcare Organizations or other appropriate accrediting body. Preference will be given in the review of competing applications to applicants who are accredited or can demonstrate a history of operating accredited facilities.

Provide the following information for each accredited nursing home that the applicant presently owns or operates in Virginia or elsewhere:

- Name, location, and bed capacity of the accredited nursing home.
- Organization granting the accreditation.
- Date when the nursing home was first accredited (by this accrediting organization) and expiration date of the present accreditation.

An applicant who owns or operates *more than ten* accredited nursing homes *outside* Virginia may summarize the response to this item by reporting the following for the accredited nursing homes *outside* Virginia:

- The number of accredited nursing homes and nursing home beds, in total, by state, and by accrediting organization.
- The approximate average length of time these nursing homes have been accredited.

Describe any plans to seek accreditation for the nursing home covered by this application, including when accreditation will be sought and from whom.

- B. Record in the Provision of Quality Care.** Preference will be given in the review of competing applications to applicants who can demonstrate a consistent pattern of licensure surveys with few deficiencies and a consistent history of few complaints.

1. Nursing Homes in Virginia. Provide a tabulation showing the results of each Medicare/Medicaid survey conducted during the last twenty-four months in each nursing home owned and/or operated *in Virginia* now or in the last twenty-four months: (i) by the *applicant* for this project, (ii) by the *owner* of the proposed nursing home (if different from the applicant), and (iii) by the

operator of the proposed nursing home (if the operator is neither the applicant nor the owner). Table IV-C below is a suggested format for the tabulation. The applicant may also provide any comments that would amplify or explain the survey results reported in Table IV-C.

Table IV-C

**Results of Medicare/Medicaid Surveys--Last Two Years
for Nursing Homes Owned and/or Operated in Virginia
by the Applicant/Owner/Operator
of the Nursing Home Proposed in This COPN Application**

Tabulation pertaining to: (i) applicant _____ (ii) owner _____ (iii) operator _____ (mark which one(s))

Name, Location of Each Nursing Home Owned or Operated in Virginia (last 2 years)	State Whether Owned, Operated, or Both	Survey Month and Year (last 2 yr.)	State Whether M'care, M'caid, or Dually Cert. (at time of survey)	Survey Type* (see note below)	Level of Compliance** (see note below)
Nursing home "A", city/county					
Most recent survey					
Next most recent survey					
Prior survey (if within last 2 yr.)					
Prior survey (if within last 2 yr.)					
Prior survey (if within last 2 yr.)					
Nursing Home "B", city/county					
Most recent survey					
Prior survey					
Prior survey (if within last 2 yr.)					
etc. for each Va. nursing home					

*Report whether the survey was a "standard" survey, an "extended" survey, an "abbreviated" survey, or a "partial extended" survey.

**Report the level of compliance found in the survey as: "in compliance" (i.e., no deficiencies), "in substantial compliance", "not in substantial compliance, but no substandard quality of care", or "substandard quality of care".

2. Nursing Homes Outside Virginia. Provide a tabulation, by state and by whether owned or operated or both, of the Medicare and Medicaid certification status and the results of the most recent "standard" or "extended" (but not "abbreviated" or "partial extended") survey for all nursing homes presently owned and/or operated in the United States *outside Virginia*: (i) by the applicant for this project, (ii) by the owner of the proposed nursing home (if different from the applicant), and (iii) by the operator of the proposed nursing home (if the operator is neither the applicant nor the owner). Table IV-D below is a suggested format for the tabulation.

Identify in the tabulation all nursing homes for which a category 2 or category 3 remedy has been formally recommended (not merely stated as a contingency) or imposed in the last twelve months. Separately, report for each such nursing home: (i) the specific remedy(ies) recommended or imposed, (ii) the current status of the remedies, and (iii) the current status of the required corrective actions. For each state in which a nursing home has had a category 2 or category 3 remedy formally recommended or imposed, provide the name, address, and telephone number of the state agency(ies) that conducted the survey and imposed or would impose the remedy.

Provide any comments that would amplify or explain the survey results reported in Table IV-D. Such comments should identify any nursing home for which a category 2 or category 3 remedy has been formally recommended, but has not been imposed, and explain why the recommended remedy has not been imposed.

Category 3 remedies (most severe) and category 2 remedies (next most severe) are:

Category 3 Remedies

- Termination
- Temporary management
- Civil money penalties \$3,050-\$10,000/day

Category 2 Remedies

- Deny payment new admissions
- Deny payment all persons
- Civil money penalties \$50-\$3,000/day

Table IV-D

**Certification Status and Most Recent Medicare/Medicaid Survey Results by State
for Nursing Homes Now Owned and/or Operated *Outside Virginia*
by The Applicant/Owner/Operator
of the Nursing Home Proposed in This COPN Application**

Tabulation pertaining to: (i) applicant _____ (ii) owner _____ (iii) operator _____ (mark which one(s))

State (all other states where applicant/owner/operator owns or operates a NH)	Total Nursing Homes	No. NH w/Fed. Certif.	Total NH Beds	No. Beds M'care Certif.	No. Beds M'caid Certif.	Number of Nursing Homes by Level of Compliance in Last Survey*				Names of NH with Cat. 2** or Cat. 3** Remedies Recom. or Imposed Last 12 Mon.
						IC	SC	NSC	SQC	
State "A"										
NH owned, not operated										
NH operated, not owned										
NH owned and operated										
State "B"										
NH owned, not operated										
NH operated, not owned										
NH owned and operated										
State "C"										
etc.										
Total US										
NH owned, not operated										
NH operated, not owned										
NH owned and operated										

*Report the level of compliance found in the most recent standard or extended survey as: IC (in compliance, i.e., no deficiencies); SC (in substantial compliance); NSC (not in substantial compliance, but no substandard quality of care); or SQC (substandard quality of care).

**See immediately preceding text for a description of category 2 and category 3 remedies.

3. History of Complaints--Virginia Nursing Homes. Report the following to describe the history of complaints over the most recent twenty-four months for each nursing home identified in Table IV-C:

- The number of complaints from nursing home residents or from persons acting on behalf of residents that generated an inquiry from any agency of the Commonwealth or of local government.
- The general subject of these complaints (e.g., nursing care, resident rights, housekeeping, charges for services, etc.).
- The number and nature of complaints that led to explicit investigation as part of any Medicare/Medicaid survey.
- Actions taken to resolve the complaints.
- Any other explanation of circumstances or factors related to the complaints described here.

- E. Consistency of the Application with the Twenty Statutory Review Criteria. The Code of Virginia prescribes twenty criteria to be considered in the review of COPN applications. A list of the statutory review criteria is attached to this application form. Some of the statutory review criteria are closely paralleled by questions in this application form, while others are not.

The applicant is asked to address the consistency of the proposed project with those particular criteria indicated below as specifically needing to be addressed by the applicant. In addition, the applicant may wish--but is not required--to comment on *any other* of the twenty criteria (see attachment to this application form) where a response from the applicant might assist the reviewer's understanding and accurate assessment of the application.

1. **Statutory Criterion. The immediate and long-term financial feasibility of the project.**

The applicant is requested to address this criterion and describe how the project was determined to be financially feasible. The response may refer to information presented in section V, "Financial Data," of the application, but the response here should also explain *how* it was determined that the project's revenues (including subsidies or donations, if applicable) are expected at least to meet the project's expenses. Generally, this will mean explaining how the projected expenses, patient service volume, payer mix, and net revenue by payer source were determined. If a formal feasibility study was prepared, provide a copy or summary of the study. If the feasibility study was prepared by someone other than the applicant, identify the preparer and describe the preparer's relevant experience, background, or credentials.

2. **Statutory Criterion. The relationship of the project to the existing health care system of the area in which the project is proposed.**

The applicant is requested to address this criterion. The response may refer to information provided under item B ("Justification") and item C ("Consistency...with the SMFP") of section IV of the application form, but the response here should comprehensively address the relationship of this project to the existing health care system of the area.

3. **Statutory Criterion. The organizational relationship of the project to necessary ancillary and support services.**

The applicant is requested to address this criterion and to describe how ancillary health care and health care support services will be obtained, when those services cannot be provided by employed staff of the proposed nursing home. In particular, address how therapy services (to the extent not provided by staff), radiology services, laboratory services, dental services, and physician services will be provided.

4. **Statutory Criterion. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.**

The applicant is requested to address the part of this criterion relating to the applicant's costs and charges. The response may refer to information provided under item C, "Costs", of section IV of the application form. However, the response in this section should comprehensively address how this project is expected to affect the applicant's existing costs and charges for providing nursing home services and any other health care services now provided by the applicant.

The applicant may wish to address also the part of this criterion relating to the impact of the project on the costs and charges of other health care providers in the area.

- F. Consistency of the Application with Health Plans and Project Review Standards of the Regional Health Planning Agency. Prior to preparing the application, the applicant should determine from the regional health planning agency whether it has adopted any health plans or project review standards that are applicable to this project. Quote or summarize those plans and project review standards here and describe how this project conforms to them.
- G. Notification of Area Inpatient Medical Care Facilities. Attach a copy or sample text of letters to other inpatient medical care facilities in the planning district and in the project's proposed primary service area that lies outside the planning district (including out-of-state areas, as appropriate), notifying these facilities of the proposed scope and development schedule of this project. List the facilities that were sent the notification letter and state when it was sent.
- H. Community and Professional Support. Attach a copy of any material that indicates community and professional support for this project; for example, letters of endorsement from physicians, other health care providers, community organizations, local governments, Chambers of Commerce, professional associations, and others.

SECTION V

FINANCIAL DATA

The applicant is expected to show adequate financial resources to complete construction of the project and to provide sufficient working capital and operating income for at least one year after the date of opening.

A. Description of Method of Financing. Describe the proposed amount(s), source(s), method(s), and expected terms of financing for the project, including the various alternatives considered, with respect to both construction financing and permanent financing, if applicable. Explain the steps taken to date to obtain the proposed financing. If an agreement (perhaps contingent on obtaining a COPN) has been reached with a lender, underwriter, or other source of financing for the project, provide documentation of that. Otherwise, provide information indicating the likelihood that the necessary financing can be obtained and the expected amount(s), source(s), and terms of the financing.

B. Summary of Anticipated Sources and Amounts of Funds for Proposed Project.

- | | |
|--|-----------------|
| 1. Public campaign | \$ _____ |
| 2. Bond issue (specify type) _____ | \$ _____ |
| 3. Commercial loans | \$ _____ |
| 4. Government loans (specify type) _____ | \$ _____ |
| 5. Grants (specify type) _____ | \$ _____ |
| 6. Bequests | \$ _____ |
| 7. Private foundations | \$ _____ |
| 8. Endowment income | \$ _____ |
| 9. Accumulated reserves | \$ _____ |
| 10. Other (identify) _____ | \$ _____ |
| 11. TOTAL ANTICIPATED FUNDS | \$ _____ |

C. Amortization Schedule. Attach an amortization schedule showing how any proposed debt will be repaid.

D. Financial Statements. Attach a copy of the audited annual financial statements for the past two years of the existing facility, or if a new facility without operating experience, the financial statement(s) of the owner(s). Audited financial statements are required, if available.

E. Estimated Capital Costs. Please see the attached "Instructions for Completing Section V, Subsection E: Estimated Capital Costs." Provide capital and financing cost data relating *only* to nursing home beds and services, even if the construction project will also provide facilities for *other than* nursing home beds and services. In such cases, briefly describe the method or basis for allocating capital and financing costs between the nursing home and any other portions of the construction project.

1. Existing Space to Be Converted to Nursing Home Use. (See instructions.)

- a. Gross square feet (GSF) of space to be converted to nursing home use _____ GSF
- b. Number of years in operation of space to be converted to nursing home use _____ years
- c. Net depreciated value of space to be converted to nursing home use \$ _____

2. Direct Construction Costs.

- a. Cost of materials \$ _____
- b. Cost of labor \$ _____
- c. Equipment included in construction contract \$ _____
- d. Builder's overhead \$ _____
- e. Builder's profit \$ _____
- f. Allocation for contingencies \$ _____
- g. **Sub-total** - Direct Construction (add lines a through f) \$ _____
- h. Distribution of direct construction costs by new construction or remodeling/modernization:
 - (1) Direct construction costs for new construction \$ _____
 - (2) Direct construction costs for remodeling/modernization \$ _____
 - (3) Total direct construction costs \$ _____
(add lines (1) and (2)--sum should be same as line 2g above)

3. Equipment Not Included in Construction Contract or Facility Lease. (List each separately.)

a. Purchased equipment:

- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____

(use additional lines as necessary)

- b. Leased equipment: (Report lease expense over entire term of lease. See instructions. Provide copy of lease(s.))

_____	\$ _____
_____	\$ _____
_____	\$ _____

(use additional lines as necessary)

- c. **Sub-total** - Equipment Not Included (add all lines under a and b) \$ _____

4. Site Acquisition Costs.

- a. Full purchase price - for sites *without* standing structures to remain in use \$ _____

- b. Full purchase price - for sites *with* standing structures to remain in use \$ _____

(1) Purchase price allocable to structures to remain in use \$ _____

(2) Balance of site purchase price (allocable to land) \$ _____

- c. If leasehold, lease expense over entire term of lease (See instructions. Provide copy of lease.) \$ _____

- d. Closing costs (legal, recording fees, etc.) \$ _____

- e. Additional expenses, paid or accrued, related to site acquisition:

_____	\$ _____
_____	\$ _____
_____	\$ _____

(use additional lines as necessary)

- f. **Sub-total** - Site Acquisition (add lines a through e, excl. b(1) and b(2)) \$ _____

5. Site Preparation Costs.

- a. Earth work \$ _____

- b. Site utilities \$ _____

- c. Roads and walks \$ _____

- d. Lawns and planting \$ _____

e. Unusual site conditions:

_____ \$ _____
_____ \$ _____

(use additional lines as necessary)

f. Accessory structures \$ _____

g. Demolition \$ _____

h. **Sub-total** - Site Preparation (add lines a through g) \$ _____

6. Off-Site Costs. *(List each separately.)*

a. _____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

(use additional lines as necessary)

b. **Sub-total** - Off-Site (add all lines under a) \$ _____

7. Architectural and Engineering Fees.

a. Architect's design fee \$ _____

b. Architect's supervision fee \$ _____

c. Engineering fees \$ _____

d. Architectural and engineering consultant's fees \$ _____

e. **Sub-total** - Architectural & Engineering (add lines a through d) \$ _____

8. Other (not A&E) Consultant Fees. *(List each separately. Include any COPN preparation fees.)*

a. _____ \$ _____

_____ \$ _____

_____ \$ _____

(use additional lines as necessary)

b. **Sub-total** - Other Consultant (add all lines under a) \$ _____

9. Taxes During Construction.

- a. Property taxes during construction \$ _____
- b. Other taxes and governmental fees related to construction (*list each separately*):
_____ \$ _____
_____ \$ _____
(use additional lines as necessary)
- c. **Sub-total** - Taxes During Construction (add lines a and b) \$ _____

10. HUD Section 232 Financing.

- a. Estimated construction time (months) _____ months
- b. Amount of construction loan \$ _____
- c. Construction loan interest rate _____%
- d. Estimated construction loan interest expense \$ _____
- e. Term of permanent financing (years) _____ years
- f. Interest rate on permanent financing _____%
- g. Anticipated amount of bond discount \$ _____
- h. FHA mortgage insurance premium \$ _____
- i. FHA mortgage fees \$ _____
- j. Financing fees \$ _____
- k. Placement fee \$ _____
- l. Legal expenses \$ _____
- m. Title and recording fees \$ _____
- n. Other fees and expenses related to financing (*list each separately*):
_____ \$ _____
_____ \$ _____
_____ \$ _____
(Use additional lines as necessary)
- o. Debt service or other reserve \$ _____

- p. Total permanent financing interest expense \$ _____
- q. **Sub-total** - HUD Section 232 Financing \$ _____
(add lines d plus h through n)

11. Industrial Development Authority (IDA) and General Obligation (GO) Bond Financing.
(Circle selected method--industrial development authority or general obligation bond.)

- a. Estimated construction time (months) _____ months
- b. Method of *construction* financing (construction loan, proceeds of bond sales, if other--specify): _____

If construction is to be financed from any source *other than bond sale* proceeds, answer questions c through e. Otherwise, go to question f.

- c. Amount of construction loan \$ _____
- d. Construction loan interest rate _____ %
- e. Estimated construction loan interest expense \$ _____
- f. Nature of bond placement (direct, underwriter, if other--specify): _____
- g. Will bonds be issued prior to the start of construction? _____ Yes _____ No
- h. If the answer to question g is yes, how long before (months)? _____ months
- i. Amount bonds to be sold *before* construction \$ _____
- j. Will *principal* and interest be paid during construction or *only* interest? _____
- k. Bond interest expense *prior* to the start of construction \$ _____
- l. How many months after construction begins will the last bond be sold? _____ months
- m. Bond interest expense *during* construction \$ _____
- n. What percentage of total construction will be financed from the bond issue? _____ %
- o. Anticipated term of bond issue (years) _____ years
- p. Expected bond interest rate _____ %
- q. Anticipated amount of bond discount \$ _____
- r. Placement fee \$ _____
- s. Feasibility study \$ _____
- t. Printing expenses \$ _____

VIRGINIA DEPARTMENT OF HEALTH

Application for a Medical Care Facilities Certificate of Public Need - Long-Term Care Facilities

COPN Request No. VA - _____

Date: _____

Page no. ____

u. Insurance \$ _____

v. Legal expenses \$ _____

w. Title and recording fees \$ _____

x. Other fees and expenses related to financing (list each separately):

_____ \$ _____

_____ \$ _____

_____ \$ _____

(use additional lines as necessary)

y. Sinking fund (debt service) reserve \$ _____

z. Bond interest expense (after construction) \$ _____

aa. **Sub-total** - IDA or GO Bond Financing \$ _____
(add lines e, k, m, and r through x)

12. Conventional Mortgage Loan Financing.

a. Estimated construction time (months) _____ months

b. Amount of construction loan \$ _____

c. Construction loan interest rate _____%

d. Estimated construction loan interest expense \$ _____

e. Term of permanent loan (years) _____ years

f. Interest rate on permanent loan _____%

g. Anticipated amount of mortgage discount \$ _____

h. Feasibility study \$ _____

i. Finder's fee \$ _____

j. Insurance \$ _____

k. Legal expenses \$ _____

l. Title and recording fees \$ _____

m. Other fees and expenses related to financing (*list each separately*):

_____	\$ _____
_____	\$ _____
_____	\$ _____

(*use additional lines as necessary*)

n. Total permanent loan interest expense \$ _____

o. **Sub-total** - Conventional Mortgage Loan Financing \$ _____
(add lines d plus h through m)

13. Estimated Capital Costs Summary Sheet.

a. Value of Existing Space to Be Converted (line 1c) \$ _____

b. Sub-total - Direct Construction Costs (line 2g) \$ _____

c. Sub-total - Equipment Not Included in Construction Contract (line 3c) \$ _____

d. Sub-total - Site Acquisition Costs (line 4f) \$ _____

e. Sub-total - Site Preparation Costs (line 5h) \$ _____

f. Sub-total - Off-Site Costs (line 6b) \$ _____

g. Sub-total - Architectural and Engineering Fees (line 7e) \$ _____

h. Sub-total - Other Consultant Fees (line 8b) \$ _____

i. Sub-total - Taxes During Construction (line 9c) \$ _____

j. Sub-total - HUD-232 Financing (line 10q) \$ _____

k. Sub-total - IDA Revenue & GO Bond Financing (line 11aa) \$ _____

l. Sub-total - Conventional Mortgage Loan Financing (line 12n) \$ _____

m. **TOTAL CAPITAL COSTS** (add lines a thru l) \$ _____

14. Percent of total capital costs (line 13m) to be financed _____%

15. Amount of long-term financing (line 13m x line 14) \$ _____

16. Total interest expense on permanent financing:

a. HUD-232 financing (line 10p) \$ _____

b. IDA revenue and GO bond financing (line 11z) \$ _____

F. Long-Term Care Actual and Estimated Revenue and Expense Statement. Please see the section "Instructions for Completing...Actual and Estimated Revenue and Expense Statement" in the attached Instructions for Completing the Application for a Medical Care Facilities Certificate of Public Need. Provide data *only for nursing home* revenues and expenses, even if the facility also includes *other than* nursing home beds and services.

Part I - Actual and Projected Utilization. Complete the following table. If the application involves an existing nursing home, report actual nursing home patient days by principal source of payment for each of the previous two years of operation. For all applications, provide the projected number of nursing home patient days by principal source of payment for each of the two years after completion of the project. If there are "Other" *nursing home* patient days, specify these payment sources.

Be sure the annual periods used and the numbers of patient days reported for them are consistent with the information reported in the attached Table III-B, "Bed Complement and Utilization." Be sure the annual periods used are the same as those used for the following parts II through VII of this subsection.

Table V-F-I

Actual and Projected Nursing Home Patient Days

Principal Source of Payment	Actual Nursing Home Patient Days: Two Years Prior to Application		Projected Nursing Home Patient Days: Two Years Following Completion	
	Yr. end: _____	Yr. end: _____	Yr. end: _____	Yr. end: _____
Medicare (SNF)				
Medicaid (NF)				
Medicaid specialized care				
Self-pay				
Other (specify: _____)				
Other (specify: _____)				
Other (specify: _____)				
Other (specify: _____)				
Other (specify: _____)				
Total				
Percent occupancy				

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT

Actual: Two Years Prior to Application		Projected: Two Years Following Completion	
*Year End:	*Year End:	*Year End:	*Year End:
____/____	____/____	____/____	____/____

(*The annual periods used here should be the same as those used in attached Table III-B and in Table V-F-1 immediately above.)

Part II - Revenue (gross revenue by resident's principal source of payment).

1. Room and Board Revenue:

a. Medicare (SNF)	\$	_____	_____	_____	_____
b. Medicaid (NF)	\$	_____	_____	_____	_____
c. Medicaid specialized care	\$	_____	_____	_____	_____
d. Self-pay	\$	_____	_____	_____	_____
e. Other principal pay. sources	\$	_____	_____	_____	_____
f. Total - Room & Board		\$	_____	_____	_____
			(add lines a through e)		

2. Pharmacy Revenue:

a. Medicare (SNF)	\$	_____	_____	_____	_____
b. Medicaid (NF)	\$	_____	_____	_____	_____
c. Medicaid specialized care	\$	_____	_____	_____	_____
d. Self-pay	\$	_____	_____	_____	_____
e. Other principal pay. sources	\$	_____	_____	_____	_____
f. Total - Pharmacy		\$	_____	_____	_____
			(add lines a through e)		

3. Laboratory Revenue:

a. Medicare (SNF)	\$	_____	_____	_____	_____
b. Medicaid (NF)	\$	_____	_____	_____	_____
c. Medicaid specialized care	\$	_____	_____	_____	_____
d. Self-pay	\$	_____	_____	_____	_____
e. Other principal pay. sources	\$	_____	_____	_____	_____
f. Total - Laboratory		\$	_____	_____	_____
			(add lines a through e)		

4. Physical Therapy Revenue:

a. Medicare (SNF)	\$	_____	_____	_____	_____
b. Medicaid (NF)	\$	_____	_____	_____	_____
c. Medicaid specialized care	\$	_____	_____	_____	_____
d. Self-pay	\$	_____	_____	_____	_____
e. Other principal pay. sources	\$	_____	_____	_____	_____
f. Total - Physical Therapy		\$	_____	_____	_____
			(add lines a through e)		

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

	Actual: Two Years Prior to Application		Projected: Two Years Following Completion	
	Year End: ____/____	Year End: ____/____	Year End: ____/____	Year End: ____/____
5. Occupational Therapy Revenue:				
a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____
f. Total - Occupational Therapy	\$ _____	_____	_____	_____
(add lines a through e)				
6. Speech Therapy Revenue:				
a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____
f. Total - Speech Therapy	\$ _____	_____	_____	_____
(add lines a through e)				
7. Incontinency Care Revenue:				
a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____
f. Total - Incontinency Care	\$ _____	_____	_____	_____
(add lines a through e)				
8. Medical Supplies Revenue:				
a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____
f. Total - Medical Supplies	\$ _____	_____	_____	_____
(add lines a through e)				

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

<u>Actual: Two Years</u>		<u>Projected: Two Years</u>	
<u>Prior to Application</u>		<u>Following Completion</u>	
<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
____/____	____/____	____/____	____/____

9. Other Patient Care Services Revenue (i.e., not included in room and board or any other revenue category above):

a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____

f. Total - Other Patient Care \$ _____
(add lines a through e)

10. Total Gross Patient Care Services Revenue (sum of data in items 1 through 9 above):

a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____

f. Total - Gross Patient Care Rev. \$ _____
(add lines a through e)

11. Deductions from Revenue (Bad Debt, Contractual Adjustments, Discounts):

a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____

f. Total - Deduct. from Revenue \$ _____
(add lines a through e)

12. Net Patient Care Services Revenue (total gross patient care services revenue minus deductions from revenue):

a. Medicare (SNF)	\$ _____	_____	_____	_____
b. Medicaid (NF)	\$ _____	_____	_____	_____
c. Medicaid specialized care	\$ _____	_____	_____	_____
d. Self-pay	\$ _____	_____	_____	_____
e. Other principal pay. sources	\$ _____	_____	_____	_____

f. Total - Net Patient Care Rev. \$ _____
(add lines a through e)

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

	Actual: Two Years Prior to Application		Projected: Two Years Following Completion	
	Year End:	Year End:	Year End:	Year End:
	____/____	____/____	____/____	____/____
13. Other (Non-Patient-Care) Revenue:				
a. Interest earned	\$ _____	_____	_____	_____
b. Meals sold	\$ _____	_____	_____	_____
c. Vending machines	\$ _____	_____	_____	_____
d. Barber, beauty, gift shops	\$ _____	_____	_____	_____
e. Other non-pat. (specify: _____)	\$ _____	_____	_____	_____
f. Other non-pat. (specify: _____)	\$ _____	_____	_____	_____
g. Misc. non-pat. revenue	\$ _____	_____	_____	_____
h. Total - Other Revenue (add lines a through g)	\$ _____	_____	_____	_____
14. Total - Net Revenue (add lines 12f and 13h)	\$ _____	_____	_____	_____

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

<u>Actual: Two Years Prior to Application</u>		<u>Projected: Two Years Following Completion</u>	
<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
____/____	____/____	____/____	____/____

Part III - Direct Patient Care Expenses (Show projected FTEs in second year following completion.):

1. Nursing Administration Expenses:

- a. Dir. of nursing (FTEs __) \$ _____
- b. Asst. dir. of nurs. (FTEs __) \$ _____
- c. Empl. bene.*- nursing svc. \$ _____
- d. Payroll taxes - nursing svc. \$ _____
- e. Other nurs. adm. (specify: __) \$ _____

*Include workers compensation in "employee benefits."

f. Total - Nursing Administration \$ _____
(add lines a through e)

2. Medicare + Medicaid (Dually) Certified Area Expenses (excl. Medicaid specialized care below):

- a. Regist. nurses (FTEs __) \$ _____
- b. Lic. pract. nurses (FTEs __) \$ _____
- c. CNAs, aides, etc. (FTEs __) \$ _____
- d. Non-personnel expenses \$ _____

e. Total - M'care + M'caid Area \$ _____
(add lines a through d)

3. Medicare (Only) Certified Area Expenses:

- a. Regist. nurses (FTEs __) \$ _____
- b. Lic. pract. nurses (FTEs __) \$ _____
- c. CNAs, aides, etc. (FTEs __) \$ _____
- d. Non-personnel expenses \$ _____

e. Total - M'care (Only) Area \$ _____
(add lines a through d)

4. Medicaid (Only) Certified Area Expenses (excl. Medicaid specialized care below):

- a. Regist. nurses (FTEs __) \$ _____
- b. Lic. pract. nurses (FTEs __) \$ _____
- c. CNAs, aides, etc. (FTEs __) \$ _____
- d. Non-personnel expenses \$ _____

e. Total - M'caid (Only) Area \$ _____
(add lines a through d)

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

<u>Actual: Two Years Prior to Application</u>		<u>Projected: Two Years Following Completion</u>	
<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
___/___	___/___	___/___	___/___

5. Medicaid Specialized Care Expenses:

a. Regist. nurses (FTEs __)	\$ _____	_____	_____	_____
b. Lic. pract. nurses (FTEs __)	\$ _____	_____	_____	_____
c. CNAs, aides, etc. (FTEs __)	\$ _____	_____	_____	_____
d. Non-personnel expenses	\$ _____	_____	_____	_____
e. Total - Medicaid Specialized Care	\$ _____	_____	_____	_____

(add lines a through d)

6. Non-Certified Unit Expenses:

a. Regist. nurses (FTEs __)	\$ _____	_____	_____	_____
b. Lic. pract. nurses (FTEs __)	\$ _____	_____	_____	_____
c. CNAs, aides, etc. (FTEs __)	\$ _____	_____	_____	_____
d. Non-personnel expenses	\$ _____	_____	_____	_____
e. Total - Non-Certified Unit	\$ _____	_____	_____	_____

(add lines a through d)

7. Total Nursing Care Area Expenses (sum of data in items 2 through 6 above):

a. Regist. nurses (FTEs __)	\$ _____	_____	_____	_____
b. Lic. pract. nurses (FTEs __)	\$ _____	_____	_____	_____
c. CNAs, aides, etc. (FTEs __)	\$ _____	_____	_____	_____
d. Non-personnel expenses	\$ _____	_____	_____	_____
e. Total - All Nursing Care Areas	\$ _____	_____	_____	_____

(add lines a through d)

8. Central Supply Expenses:

a. CS salaries (FTEs __)	\$ _____	_____	_____	_____
b. Empl. benefits*	\$ _____	_____	_____	_____
c. Payroll taxes	\$ _____	_____	_____	_____
d. Routine supplies	\$ _____	_____	_____	_____
e. Other non-pers. expenses	\$ _____	_____	_____	_____
f. Total - Central Supply	\$ _____	_____	_____	_____

(add lines a through e)

*Include workers compensation in "employee benefits."

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

	Actual: Two Years Prior to Application		Projected: Two Years Following Completion	
	Year End: ____/____	Year End: ____/____	Year End: ____/____	Year End: ____/____
9. Ancillary Services Expenses:				
a. Phys. ther. sal. (FTEs__)	\$ _____	_____	_____	_____
b. Occu. ther. sal. (FTEs__)	\$ _____	_____	_____	_____
c. Speech ther. sal. (FTEs__)	\$ _____	_____	_____	_____
d. Resp. ther. sal. (FTEs__)	\$ _____	_____	_____	_____
e. Other ancil. sal. (FTEs__)	\$ _____	_____	_____	_____
f. Empl. benefits*	\$ _____	_____	_____	_____
g. Payroll taxes	\$ _____	_____	_____	_____
h. Laboratory expenses	\$ _____	_____	_____	_____
i. Medical supplies	\$ _____	_____	_____	_____
j. Oxygen	\$ _____	_____	_____	_____
k. Other ancil. exp. (identify: __)	\$ _____	_____	_____	_____
l. Other ancil. exp. (identify: __)	\$ _____	_____	_____	_____
m. Other ancil. exp. (identify: __)	\$ _____	_____	_____	_____
n. Other ancil. exp. (identify: __)	\$ _____	_____	_____	_____

*Include workers compensation in "employee benefits."

o. Total - Ancillary Services \$ _____
(add lines a through n)

10. Summary - Direct Patient Care Expenses (sum of data in items 1 plus 7 through 9 above):

a. Pers. salaries (FTEs__)	\$ _____	_____	_____	_____
b. Employee benefits*	\$ _____	_____	_____	_____
c. Payroll taxes	\$ _____	_____	_____	_____
d. All other dir. pat. care exp.	\$ _____	_____	_____	_____

*Include workers compensation in "employee benefits."

e. Total - Direct Pat. Care Exp. \$ _____
(add lines a through d)

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

Actual: Two Years Prior to Application		Projected: Two Years Following Completion	
Year End:	Year End:	Year End:	Year End:
____/____	____/____	____/____	____/____

Part IV - Indirect Patient Care Expenses (Show projected FTEs in second year following completion.):

1. Administration and General Expenses:

a. Administrator sal. (FTEs__)	\$ _____	_____	_____	_____
b. Asst. admin. sal. (FTEs__)	\$ _____	_____	_____	_____
c. Bus. office sal. (FTEs__)	\$ _____	_____	_____	_____
d. Admissions sal. (FTEs__)	\$ _____	_____	_____	_____
e. Other admin. sal. (FTEs__)	\$ _____	_____	_____	_____
f. Employee benefits*	\$ _____	_____	_____	_____
g. Payroll taxes	\$ _____	_____	_____	_____
h. Home office charges	\$ _____	_____	_____	_____
i. Management fees	\$ _____	_____	_____	_____
j. Other A&G expenses	\$ _____	_____	_____	_____

*Include workers compensation in "employee benefits."

k. Total - Admin. and General \$ _____
(add lines a through j)

2. Plant Operations and Maintenance Expenses:

a. Plant & maint. sal. (FTEs__)	\$ _____	_____	_____	_____
b. Empl. benefits*	\$ _____	_____	_____	_____
c. Payroll taxes	\$ _____	_____	_____	_____
d. Utilities (incl. util. taxes)	\$ _____	_____	_____	_____
e. Purchased services	\$ _____	_____	_____	_____
f. Other plant & maint. exp.	\$ _____	_____	_____	_____

*Include workers compensation in "employee benefits."

g. Total - Plant Opns. & Maint. \$ _____
(add lines a through f)

3. Laundry & Linen Expenses:

a. Laundry salaries (FTEs__)	\$ _____	_____	_____	_____
b. Empl. benefits*	\$ _____	_____	_____	_____
c. Payroll taxes	\$ _____	_____	_____	_____
d. Linen purchases	\$ _____	_____	_____	_____
e. Purchased services	\$ _____	_____	_____	_____
f. Other laundry exp.	\$ _____	_____	_____	_____

*Include workers compensation in "employee benefits."

g. Total - Laundry and Linen \$ _____
(add lines a through f)

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

	<u>Actual: Two Years</u>		<u>Projected: Two Years</u>	
	<u>Prior to Application</u>		<u>Following Completion</u>	
	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
	____/____	____/____	____/____	____/____
4. Housekeeping Expenses:				
a. Housekeep. sal. (FTEs__)	\$	_____	_____	_____
b. Empl. benefits*	\$	_____	_____	_____
c. Payroll taxes	\$	_____	_____	_____
d. Other housekeep. exp.	\$	_____	_____	_____
*Include workers compensation in "employee benefits."				
e. Total - Housekeeping	\$	_____	_____	_____
(add lines a through d)				
5. Dietary Expenses:				
a. Dietary salaries (FTEs__)	\$	_____	_____	_____
b. Empl. benefits*	\$	_____	_____	_____
c. Payroll taxes	\$	_____	_____	_____
d. Raw food	\$	_____	_____	_____
e. Dietary consultants	\$	_____	_____	_____
f. Other dietary exp.	\$	_____	_____	_____
*Include workers compensation in "employee benefits."				
g. Total - Dietary	\$	_____	_____	_____
(add lines a through f)				
6. Nursing Administration Expenses (**indirect patient care expenses, not included in nurs. admin. direct care above):				
a. Nurs. adm. sal.** (FTEs__)	\$	_____	_____	_____
b. Empl. benefits*	\$	_____	_____	_____
c. Payroll taxes	\$	_____	_____	_____
d. Purchased services	\$	_____	_____	_____
e. Other indir. care nurs. adm.	\$	_____	_____	_____
*Include workers compensation in "employee benefits."				
f. Total - Nurs. Adm. (indir. care only)	\$	_____	_____	_____
(add lines a through e)				
7. Social Services Expenses:				
a. Social svc. sal. (FTEs__)	\$	_____	_____	_____
b. Empl. benefits*	\$	_____	_____	_____
c. Payroll taxes	\$	_____	_____	_____
d. Other social svc. exp.	\$	_____	_____	_____
*Include workers compensation in "employee benefits."				
e. Total - Social Services	\$	_____	_____	_____
(add lines a through d)				

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

<u>Actual: Two Years Prior to Application</u>		<u>Projected: Two Years Following Completion</u>	
<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
____/____	____/____	____/____	____/____

8. Recreation and Activities Expenses:

- a. Rec. & activ. sal. (FTEs __) \$ _____
 - b. Empl. benefits* \$ _____
 - c. Payroll taxes \$ _____
 - d. Other rec. and activ. exp. \$ _____
- *Include workers compensation in "employee benefits."
- e. Total - Recreation and Activities** \$ _____
(add lines a through d)

9. Summary - Indirect Patient Care Expenses (sum of data in items 1 through 8 above):

- a. Pers. salaries (FTEs __) \$ _____
 - b. Employee benefits* \$ _____
 - c. Payroll taxes \$ _____
 - d. All other indir. care exp. \$ _____
- *Include workers compensation in "employee benefits."
- e. Total - Indirect Pat. Care Exp.** \$ _____
(add lines a through d)

Part V - Expenses Other than Direct and Indirect Patient Care.

10. Nurse Aide Training and Competency Evaluation Program (NATCEP) Expenses:

- a. NATCEP pers. (FTEs __) \$ _____
 - b. Empl. benefits* \$ _____
 - c. Payroll taxes \$ _____
 - d. Other NATCEP expenses \$ _____
- *Include workers compensation in "employee benefits."
- e. Total - NATCEP** \$ _____
(add lines a through d)

11. Capital-Related Expenses:

- a. Depreciation \$ _____
 - b. Amortization \$ _____
 - c. Interest on capital debt \$ _____
 - d. Property taxes (real & pers.) \$ _____
 - e. Insurance (property) \$ _____
 - f. Rental exp. (capital assets) \$ _____
- g. Total - Capital-Related** \$ _____
(add lines a through f)

LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT (continued)

<u>Actual: Two Years</u>		<u>Projected: Two Years</u>	
<u>Prior to Application</u>		<u>Following Completion</u>	
<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>	<u>Year End:</u>
____/____	____/____	____/____	____/____

Part VI - Expenses Summary.

1. Total Expenses Summary:

a. Direct patient care exp.	\$ _____	_____	_____	_____
b. Indirect patient care exp.	\$ _____	_____	_____	_____
c. NATCEP expenses	\$ _____	_____	_____	_____
d. Capital-related expenses	\$ _____	_____	_____	_____
e. Total - All Expenses (add lines a through d)	\$ _____	_____	_____	_____

2. Per Diem Expenses Summary (Divide each category of total expenses for each annual period by the number of patient days provided or projected for that period. The annual periods and numbers of patient days used should be the same as shown in Table V-F-1 above and Table III-B attached. See section III.B.1 and section V.F, Part I, of the application form.):

a. Direct patient care exp.	\$ _____	_____	_____	_____
b. Indirect patient care exp.	\$ _____	_____	_____	_____
c. NATCEP expenses	\$ _____	_____	_____	_____
d. Capital-related expenses	\$ _____	_____	_____	_____
e. Total - All Expenses (add lines a through d)	\$ _____	_____	_____	_____

Part VII - Data Summary Sheet: Statement of Net Revenue, Expenses, and Net Income.

1. Total net revenue (line II.14)	\$ _____	_____	_____	_____
2. Total expenses (line VI.1.e)	\$ _____	_____	_____	_____
3. Net Income (before income taxes) (subtract line 2 from line 1)	\$ _____	_____	_____	_____

Part VIII - Schedule of Room Rates.

In Table V-F-2 below, show proposed room rates (general routine care charges) for the first two years after completion of the project. If the application involves an existing nursing home, show current and prior-year room rates. Show the *beginning* date of each year for which rates are reported. If room rates changed or are expected to change at times other than the beginning of a year, report the *average* rate for the year indicated.

If *sub-acute care* rates are shown, explain the basis for distinguishing sub-acute care from skilled care or general nursing home care. Describe what services will be provided and what types of patient conditions will be treated in sub-acute care that will not be found in other units of the proposed nursing home.

Table V-F-2

Schedule of Recent and Proposed Nursing Home Room Rates (Charges for General Routine Care) by Level of Care and Type of Accommodation

Nursing Home Level of Care and Type of Accommodation	Current Number Beds of This Type	Proposed Number Beds After Project Complete	Average Room Rate Prior Year Year Begin.: ___/___	Average Room Rate Current Year Year Begin.: ___/___	Average Room Rate 1st Year After Project Year Begin.: ___/___	Average Room Rate 2nd Year After Project Year Begin.: ___/___
*Sub-acute						
Private room						
Semi-private room						
Three or more beds						
All sub-acute rooms						
Skilled						
Private room						
Semi-private room						
Three or more beds						
All skilled rooms						
General						
Private room						
Semi-private room						
Three or more beds						
All general rooms						
Total						
Private room						
Semi-private room						
Three or more beds						
All rooms						

*Explain what constitutes sub-acute care in this facility. See preceding text.

SECTION VI

ASSURANCES

I hereby assure and certify that:

- (a) the work on the proposed project will be initiated within the period of time set forth in the Certificate of Public Need; and
- (b) completion of the proposed project will be pursued with reasonable diligence; and
- (c) the proposed project will be constructed, operated, and maintained in full compliance with all applicable local, State, and Federal laws, rules, regulations, and ordinances.

I hereby certify that the information included in this application and all attachments are correct to the best of my knowledge and belief and that it is my intent to carry out the proposed project as described.

Signature of authorizing officer

Address - line 1

Type/print name of authorizing officer

Address - line 2

Title of authorizing officer

City, state, and ZIP

Date

Telephone number

Mail or deliver (fax not acceptable) copies of the application to:

**A. Virginia Department of Health
 Division of Certificate of Public Need
 3600 West Broad St., Room 216
 Richmond, Virginia 23230
 Tel: (804) 367-2126
 (Send two copies.)**

**B. The regional health planning agency which serves the area where the project will be located.
 (Refer to the list of regional health planning agencies and addresses at the beginning of the instructions. Send one copy.)**

Attachments: Instructions for Completing the Application (revised October, 1997)
Table II-F, Tabulation of Space by Functional Area
Table III-B, Bed Complement and Utilization
Table III-C, Facility Staffing
Statutory Criteria for Review of COPN Applications

Table II-F

TABULATION OF SPACE BY FUNCTIONAL AREA

Functional Area	Existing (incl. previously approved, but unbuilt) Square Feet	Estimated Square Feet of New Construction	Estimated Square Feet to be Remodeled or Renovated	Total Square Feet After Completion of Project
NURSING UNITS				
Patient rooms and toilets (no. rooms: _____)				
Nursing unit service areas (nurs. stat., etc.)				
Day rooms, solariums, etc.				
Nursing unit circulation				
Other (specify: _____)				
Sub-Total Nursing Units				
ADULT CARE RESIDENCE UNITS				
Resident rooms and toilets (no. rooms: _____)				
Residential unit service areas				
Day rooms, solariums, etc.				
Residential unit circulation				
Other (specify: _____)				
Sub-Total ACR Units				
SUPPORT AREAS (including <i>intra</i> -departmental circulation)				
Public lobby				
Administration				
Physical therapy				
Occupational therapy				
Other therapy				
Exam/treatment rooms				
Beauty shop and canteen				
Chapel				
Kitchen and dietary department				
Patient dining				
Recreation and activities rooms				
Staff dining, lounge, lockers				
Laundry				
Housekeeping and maintenance				
General storage and receiving dock				
Mechanical equip. and engineering services				
Circulation, corridors, stairs (<i>inter</i> -department)				
Other (specify: _____)				
Other (specify: _____)				
Other (specify: _____)				
Sub-Total Support Areas				
FACILITY TOTAL - Sum of Above				
TOTAL GROSS SQUARE FEET				

Note: Compute and report square feet by functional area in a manner which approximates the concept of gross square feet as closely as can conveniently be calculated. The final line, "Total Gross Square Feet," should be the *independently* determined gross area of the facility, based on *exterior* building dimensions.

Table III-B
BED COMPLEMENT AND UTILIZATION

Data Element	Last Three Years of Operation <i>(if an existing facility is involved in the application)</i>		Beds to Be Built	Beds to Be Lost or Removed	Total Beds When Project Complete	Projected First Two Years After Project Completion	
	Year end: ____/____/____ *Year end: ____/____/____	Year end: ____/____/____ *Year end: ____/____/____				*Year end: ____/____/____	*Year end: ____/____/____
Licensed Beds							
Medicare (only)-certified beds							
Medicaid (only)-certified beds							
Medicare+Medicaid-certified beds							
Non-certified beds							
Total Licensed Nursing Home Beds							
Adult care residence beds							
Other beds (specify: _____)							
Total Non-Nursing Home Lic. Beds							
Total Facility Licensed Beds							
Licensed Bed Assignment (NH beds)							
Beds in one-bed rooms							
Beds in two-bed rooms							
Beds in rooms with three or more beds							
Total Licensed Nursing Home Beds							
Patient/Resident Days of Care							
Medicare patient days							
Medicaid patient days							
Other nursing home patient days							
Total Nursing Home Days of Care*							
Percent occupancy nursing home							
Adult care residence days							
Other days of care (specify: _____)							
Total Non-Nursing Home Days							
Total Facility Days of Care							

*The annual periods used in this table and the patient days reported for them should be the same as those shown in Table V-F-1 and in the "Long-Term Care Actual and Estimated Revenue and Expense Statement" (section V-F) of the application form.

Table III-C
 FACILITY STAFFING

Job Title	Current Average Annual Salary	Current Hourly Consult. Fee	Existing Nursing Home		Proposed Nurs. Home 2nd Year After Completion		Existing Adult Care Residence		Proposed ACR 2nd Year After Completion		Existing Total Facility		Proposed Total Facility 2nd Year After Completion	
			FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours
Nursing Services														
Medical director														
Director of nursing														
Staff development coordinator														
Registered nurse														
Ventilator nurse														
Licensed practical nurse														
Certified nurse assistant														
Certified ventilator technician														
Ward clerk														
Other nursing service ()														
Other nursing service ()														
Total Nursing Services														
Ancillary Patient Care														
Physical therapist														
Physical therapy assistant														
Physical therapy aide														
Rehabilitation aide														
Occupational therapist														
Recreational therapist														
Speech therapist														
Audiologist														
Oxygen therapist														
Tube feeding therapist														
Therapy asst. aide (excl. PT)														
Laboratory technician														
Pharmacist														
Other ancillary care ()														
Other ancillary care ()														
Total Ancillary Services														

VIRGINIA DEPARTMENT OF HEALTH
 Application for a Medical Care Facilities Certificate of Public Need - Long-Term Care Facilities
 COPN Request No. VA - _____ Date: _____

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Job Title	Current Average Annual Salary	Current Hourly Consult. Fee	Existing Home Nursing		Proposed Nurs. Home 2nd Year After Completion		Existing Adult Care Residence		Proposed ACR 2nd Year After Completion		Existing Total Facility		Proposed Total Facility 2nd Year After Completion	
			FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours
Social Work Services														
Social services director														
Social services assistant														
MSW consultant														
BSW consultant														
Other social service ()														
Total Social Work Services														
Activity Services														
Activity director														
Activity assistant														
Activity consultant														
Other activity service ()														
Total Activity Services														
Dietary Services														
Licensed dietician														
Food service supervisor														
Cook														
Dietary aide														
Other dietary service ()														
Total Dietary Services														
Housekeeping & Laundry														
Housekeeping supervisor														
Laundry supervisor														
Housekeeping aide														
Laundry aide														
Other hskp., laundry ()														
Total Housekeep. & Laundry														
Maintenance														
Maintenance supervisor														
Maintenance assistant														
Janitor														
Other maintenance ()														
Total Maintenance														

VIRGINIA DEPARTMENT OF HEALTH
 Application for a Medical Care Facilities Certificate of Public Need - Long-Term Care Facilities
 COPN Request No. VA - _____

Date: _____

Page no. _____

Job Title	Current Average Annual Salary	Current Hourly Consult. Fee	Existing Nursing Home		Proposed Nurs. Home 2nd Year After Completion		Existing Adult Care Residence		Proposed ACR 2nd Year After Completion		Existing Total Facility		Proposed Total Facility 2nd Year After Completion	
			FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours	FTEs	Annual Consult. Hours
Administration														
Administrator														
Assistant administrator														
Administration secretary														
Admissions coordinator														
Business office dir./bookkeeper														
Supply clerk														
Other administration ()														
Other administration ()														
Total Administration														
Other ()														
Other ()														
Other ()														
Other ()														
Total Personnel														

STATUTORY CRITERIA FOR REVIEW OF COPN APPLICATIONS

Presented below (boldface type) are twenty general criteria prescribed in the Code of Virginia to be applied to review of an application for a certificate of public need. Following some of the criteria are instructions to the COPN applicant regarding information relating to the criterion that the applicant should provide. Also, see section IV.E of the COPN application form.

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

The application is not able to address this criterion, since the regional health planning agency has not yet reviewed the application.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board, and the Board of Health.

This criterion is addressed in section IV of the application form.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

This criterion is addressed in section II.D of the application form.

4. The need that the population served or to be served by the project has for the project.

This criterion is addressed in section IV of the application form. The applicant may--but is not required--to provide additional comment or a summary statement here.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

This criterion is substantially addressed in section IV.C, "Accessibility", of the application form. The applicant may--but is not required--to provide additional comment or a summary statement here.

6. The area, population, topography, highway facilities, and availability of the services to be provided by the project in the particular part of the health planning region in which the project is proposed.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

8. The immediate and long-term financial feasibility of the project.

The applicant is requested to address this criterion in section IV.E of the application form.

9. The relationship of the project to the existing health care system of the area in which the project is proposed.

The applicant is requested to address this criterion in section IV.E of the application form.

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

The applicant is requested to address this criterion in section IV.E of the application form.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health planning region in which the project is to be located.

14. The need and the availability in the health planning region for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

15. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

16. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

17. The costs and benefits of the construction associated with the proposed project.

18. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

The applicant is requested to address this criterion in section IV.E of the application form.

19. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

20. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed.

COMMONWEALTH OF VIRGINIA

INSTRUCTIONS

FOR COMPLETING THE APPLICATION

FOR A MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED

(Chapter 4, Article 1:1 Of Title 32.1,

Sections 32.1-102.1 through 32.1-102.12

The Code of Virginia (1950), as amended)

LONG-TERM CARE FACILITIES

NOTE: *The complete set of application materials includes the main application form, these instructions, and four other attachments listed on page 45 of the application form.*

CONSULTATION PRIOR TO PREPARING AN APPLICATION

Before preparing the application, the applicant should contact the Division of Certificate of Public Need of the Virginia Department of Health and the appropriate Regional Health Planning Agency (RHPA) concerning existing community health resources and the projected need for the proposed project. Of particular importance is a discussion of the required information necessary to complete the application. Copies of the applicable standards from the State Medical Facilities Plan and any applicable RHPA plans and policies will be made available upon request.

The Division of COPN and the RHPAs can be contacted at the following addresses and telephone numbers:

Commonwealth of Virginia:

Virginia Department of Health	(804) 367-2126
Division of COPN	FAX (804) 367-2206
3600 West Broad Street, Suite 216	
Richmond, Virginia 23219	

Health Planning Region I:

Northwestern Virginia Health Systems Agency	(804) 977-6010
1924 Arlington Boulevard, Suite 211	FAX (804) 977-0748
Charlottesville, Virginia 22903	

Health Planning Region II:

Health Systems Agency of Northern Virginia	(703) 573-3100
7245 Arlington Boulevard, Suite 300	FAX (703) 573-1276
Falls Church, Virginia 22042	

Health Planning Region III:

Southwest Virginia Health Systems Agency	(540) 362-9528
3100A Peters Creek Road, N.W.	FAX (540) 362-9676
Roanoke, Virginia 24019	

Health Planning Region IV:

Central Virginia Health Planning Agency	(804) 233-6206
P.O. Box 24287	FAX (804) 233-8834
Richmond, Virginia 23224	

Health Planning Region V:

Eastern Virginia Health Systems Agency	(757) 461-4834
18 Koger Executive Center, Suite 232	FAX (757) 461-3255
Norfolk, Virginia 23502	

PREPARATION AND ORGANIZATION OF THE APPLICATION

General. All regular text prepared by the applicant should be in a typeface (font) of not less than ten points in size. All tables, other numeric material, and limited special text prepared by the applicant should be in a typeface of not less than eight points in size. All material, whether prepared by the applicant or prepared by others and submitted as an attachment to the application, must be *fully legible as submitted* and capable of being *legibly reproduced* on a typical office copy machine.

Body of the Application. The preferred method of preparing the application is for the applicant to reproduce the application questions on his own word processing equipment and to answer each question immediately following that question (for longer-answer questions) or in the specific blank space provided (for most short-answer questions). Upon request, the Division of COPN will provide a diskette copy of the application form.

Text portions of the application should be prepared on standard paper and placed in a *loose-leaf ring binder* that permits convenient insertion and removal of individual pages. (Plastic spiral-bound, stapled, Acco-fastener, or other similar methods of assembly are *not* desirable.) Any later amendments or additions to the application (including responses to the Department's "completeness" questions) should be prepared as *whole-page replacements or additions* to be inserted in the proper place in the ring binder.

Each page in the body of the application, including any replacement or additional pages filed later, should show the assigned COPN request number, the date of the material, and the page number. (If necessary, page numbers may be subdivided, 1.1, 1.2, etc., to accommodate additional pages filed later.)

Attachments to the Application. If the response to a question on the application form incorporates a separate document (e.g., legal document, separate study, drawing, etc.) or is extremely long, the response may be provided in whole or in part as a separate exhibit or attachment to the application. All exhibits or attachments should be presented sequentially, immediately following section VI "Assurances" of the application form. An index or list of all attachments should precede the first one.

Each exhibit or attachment to the application must be labeled to identify the section of the application form to which it relates. For example, an attached partnership agreement should be labeled as attachment (exhibit) I-E-1, because it responds to section I-E-1 of the application form. Similarly, an attached copy of a financial feasibility study should be labeled as attachment (exhibit) IV-E-1, because it responds to section IV-E-1 of the application.

In so far as possible, all attachments to the application should be placed in the ring binder with the body of the application. Drawings or other items prepared on oversized sheets should be folded, placed in plastic pockets, and included in the ring binder in the correct sequence, behind a properly labeled divider. An unusually bulky attachment or a bound document unsuitable for the ring binder may be presented separately from the ring binder and labeled to show the section of the application form to which it relates.

Each attachment should be separated from surrounding material by a tabbed divider sheet or some other device (labeled to show the related section of the application form) that will enable the reader of the application to quickly find any particular attachment.

INSTRUCTIONS FOR COMPLETING SECTION V, SUBSECTION E:
ESTIMATED CAPITAL COSTS

GENERAL

If additional space is required, attach a separate sheet and show the line number to which the additional information relates. Spaces left blank will be interpreted to mean zero or not applicable.

Provide capital and financing cost data relating *only* to nursing home beds and services, even if the construction project will also provide facilities for *other than* nursing home beds and services. In such cases, briefly describe the method or basis for allocating capital and financing costs between the nursing home and any other portions of the construction project.

SECTION V, SUBSECTION E, ITEM 1
EXISTING SPACE TO BE CONVERTED TO NURSING HOME USE

Conversion (reassignment) of existing space for use in a COPN-reviewable project represents a consumption of resources on behalf of the COPN project, just as new construction would. It therefore is considered part of the project cost. Report the cost of the space to be converted as the net depreciated value of the space, determined from the facility's accounting records. (*Exclude* from this amount any remodeling or modernization costs to convert the space to the planned new use. These costs are to be reported in item E.2.)

SECTION V, SUBSECTION E, ITEM 2
DIRECT CONSTRUCTION COSTS

Report the planned expenditures for the construction, remodeling, or modernization of the primary structure(s) and for all equipment included in the construction contract, such as life support systems, communications systems, central vacuuming, etc.

SECTION V, SUBSECTION E, ITEM 3
EQUIPMENT NOT INCLUDED IN CONSTRUCTION CONTRACT OR FACILITY LEASE

List and price the depreciable equipment to be purchased which was *not* supplied as part of the construction contract (line 2c above) or not included in the lease of a leased facility (line 4c below). This generally includes equipment not permanently affixed to the structure. Examples include x-ray equipment, beds, freezers, etc.

List the equipment to be leased (other than that included in a facility lease, line 4c below), and report the entire contract lease amount summed over the full term of the lease. Ignore any *optional* extensions or renewals of the lease. Ignore lease *escalator* provisions, unless they are *fixed* in amount or percentage at the time the lease is executed. (For example, ignore escalator provisions tied to an inflation index or tied to undetermined future utilization of the equipment.)

SECTION V, SUBSECTION E, ITEM 4
SITE ACQUISITION COSTS

Report the cost of acquiring the site for the project covered by this application. If the site will serve more uses than just the project covered by this application, include only that portion of the total site purchase price that is appropriately allocable to the land area to serve this project. If an existing structure is included in the site purchase price, *and* it is anticipated that this structure *will continue to be used* for any purpose, apportion the total site purchase price between the value of the existing structure and the value of the raw land (lines 4b(1) and 4b(2)).

For a leased facility or leased site, report the entire contract lease amount summed over the full term of the lease. Ignore any *optional* extensions or renewals of the lease. Ignore lease *escalator* provisions, unless they are *fixed* in amount or percentage at the time the lease is executed. (For example, ignore escalator provisions tied to an inflation index or tied to undetermined future expenses of the landlord.)

SECTION V, SUBSECTION E, ITEM 5
SITE PREPARATION COSTS

Report the expenses of site preparation work related to the project covered by this application. If the site will serve more uses than just the project covered by this application, apportion the site preparation expenses accordingly. Earth work (line a) refers primarily to land contouring. Site utilities (line b) include the installation of water, sewer, electric, and gas utilities. Roads and walks (line c), lawns and planting (line d), and unusual site conditions (line e) refer to expenses for *on-site* work only. Accessory structures (line f) are unattached structures, such as storage buildings, garages, etc., to be used in support of the project covered by this application. Demolition expenses (line g) are those incurred in clearing standing structures from the project site.

SECTION V, SUBSECTION E, ITEM 6
OFF-SITE COSTS

Report expenses for off-site work, such as extension of utilities to the site, modification of highways for safe entrance, etc., which will serve the project covered by this application.

SECTION V, SUBSECTION E, ITEM 9
TAXES DURING CONSTRUCTION

Estimate the property taxes to be paid during the construction period. For multiple-use sites, include only that portion of total property taxes allocable to the project and its supporting land area covered by this application. List any other taxes or government fees, such as permit fees, utility taxes, etc., expected to be paid during the construction period.

SECTION V, SUBSECTION E, ITEM 10
HUD SECTION 232 FINANCING

or

SECTION V, SUBSECTION E, ITEM 11
INDUSTRIAL DEVELOPMENT AUTHORITY REVENUE
AND GENERAL OBLIGATION BOND FINANCING

or

SECTION V, SUBSECTION E, ITEM 12
CONVENTIONAL MORTGAGE LOAN FINANCING

Complete item 10, item 11, or item 12, according to the method of financing for the project.

INSTRUCTIONS FOR COMPLETING SECTION V, SUBSECTION F:
LONG-TERM CARE ACTUAL AND ESTIMATED REVENUE AND EXPENSE STATEMENT

GENERAL

Project nursing home revenue and expense data for the first two years of operation after project completion. Indicate the final month of the year to which the data applies. Be sure the annual periods used in this subsection agree with those used in Table III-B, attached to the application form, and in Table V-F-1. If the project includes an existing nursing home, the projected revenue and expense data should cover the existing nursing home along with the nursing home addition or changes proposed.

Base all projections of future revenue and expenses on *current* levels of wages and prices, on *current* third-party reimbursement rates that would apply to the proposed facility *if it were in operation at the time the application is submitted*, and on the facility's *proposed* charges *immediately following project completion*. Do not incorporate any allowance for inflation. (Please see the note on page 6 for discussion of circumstances where projected increases in rates would *not* reflect inflation and *should* be incorporated into the revenue projections presented in the application.)

If the project includes an existing nursing home, provide actual revenue and expenses for the existing nursing home for the past two years. Indicate the final month of the year to which the data applies.

If the facility includes beds or services for *other than* nursing home patients, provide revenue and expense data that relates *only* to the nursing home services and the nursing home portion of the facility.

If additional space is required, attach a separate sheet and show the line number to which the separate information relates. Spaces left blank will be interpreted to mean zero or not applicable.

SECTION V, SUBSECTION F, PART II
REVENUE

Report patient care revenue according to the *principal* source of payment for each nursing home patient. For example, if a patient's *principal* source of payment is Medicaid, report *all* payment on behalf of that patient as Medicaid, even though some of the payment may have been made directly by the patient as part of the required patient co-insurance.

"Medicaid specialized care" refers to several categories of very intensive nursing home care, as defined by the Virginia Department of Medical Assistance Services (DMAS). Medicaid specialized care is given to

Medicaid patients approved for such care in nursing homes designated by DMAS as authorized to provide this care and eligible to receive the special reimbursement rates established for it.

In each patient care service revenue category, "Other" revenue is all payment received on behalf of patients whose *principal* source of payment is *other* than Medicare, Medicaid, or self-pay. These other sources may include Veterans Administration, commercial insurance, HMOs, local government, etc.

Describe the principal assumptions used in the revenue projections, so that reviewers of the application can assess the reliability of the projections. Key assumptions for the revenue projections might include the projected mix of patients by principal payment source and the projected frequency of particular patient conditions that will require specific ancillary services and produce ancillary services revenue. The revenue projections should be consistent with the utilization and payer-source information provided in Table V-F-1 and the room-rate information provided in Table V-F-2 (except as noted just below).

Report "Other Revenue," i.e., *non-patient* care revenue, in lines 13a through 13h.

Base all projections of future revenue on the facility's *proposed* charges *immediately following project completion* and on *current* methodologies, parameters, and rates for third-party reimbursement that would apply to the *proposed* facility *if it were in operation at the time the application is submitted*. Do not incorporate any allowance for *inflation* of rates beyond the levels in effect at the time the application is submitted.

(NOTE: "Inflation" is an increase in the price, charge, or rate for a specific and fixed unit of service. If the unit of service changes in content or character, and if that change results in a higher reimbursement rate, "inflation" has not occurred. For example, if a nursing home's Medicaid patient mix becomes more "service-intensive," the Medicaid rate will subsequently increase. Such a rate increase does not constitute "inflation." Also, if an existing nursing home expands, the new construction at today's costs will likely result in an increase in Medicaid-reimbursable plant cost per patient day. Since the increased plant reimbursement rate results from the normal application of the current reimbursement methodology and not from an "inflation" allowance, this increased revenue should be included in the revenue projections presented in the application.)

SECTION V, SUBSECTION F, PART III THROUGH PART VI

The categorization and definition of expenses used for the COPN application form follow those employed by the Virginia Medicaid program. Applicants are expected to be familiar with the expense-reporting instructions of the Virginia Medicaid program. The instructions here are not intended to replicate or substitute for those from Virginia Medicaid. *All* actual and estimated expenses that would be reported in a *standard* income statement should be shown here, whether or not they are reimbursable by the Virginia Medicaid program.

Describe the principal assumptions used in the expense projections, so that reviewers of the application can assess the reliability of the projections. Key assumptions for the expense projections might include the projected frequency of particular patient conditions that will require specific ancillary services and result in ancillary services expenses.

The expense projections should be consistent with the compensation and staffing information provided in Table III-C, attached to the application form. Show the number of full-time equivalent (FTE) personnel in the places indicated. An FTE is defined as 2,080 paid hours per year. For facilities that use a 7.5-hour work day for nursing staff, use 1,950 hours to calculate FTEs, and note that this is the definition of nursing staff FTEs that was used.

VIRGINIA DEPARTMENT OF HEALTH

Instructions for Preparing the Application for a Medical Care Facilities Certificate of Public Need
Long-Term Care Facilities

Base all projections of future expenses on the *current* level of wages and prices that would apply to this facility. Do not incorporate any allowance for inflation.

SECTION V, SUBSECTION F, PART III
DIRECT PATIENT CARE EXPENSES

Part III deals with "direct" patient care expenses, as defined by the Virginia Medicaid program.

All employee benefit and payroll tax expenses for nursing personnel are included in nursing administration expenses. Nursing care expenses (other than nursing administration) are further subdivided by certification unit and Medicaid specialized care beds within the nursing home. Each subdivision of nursing care expenses asks for "non-personnel expense," such as minor supplies or materials whose expense is not reported elsewhere, for example in central supply.

SECTION V, SUBSECTION F, PART IV
INDIRECT PATIENT CARE EXPENSES

Part IV deals with "indirect" patient care expenses, as defined by the Virginia Medicaid program.

In "Other A&G expenses," include such items as travel, vehicle operation and maintenance, employee education, professional publications, telephone, management consulting services (not included in home office charges or management fees), liability or other non-property insurance, licenses and permits, taxes not properly classifiable elsewhere, rental or purchase of non-depreciable office equipment, office supplies, and similar items not properly classifiable elsewhere. Do not include personal property taxes on depreciable equipment and real property taxes here. Report them in "capital-related expense." Do not report *income* taxes.

Note the Virginia Medicaid program's distinction between direct care and indirect care expenses for nursing administration, and report them accordingly. Be sure they are neither overstated by duplication nor understated by incompleteness.

SECTION V, SUBSECTION F, PART V
EXPENSES OTHER THAN DIRECT AND INDIRECT PATIENT CARE

Report depreciation of the building and related improvements on the site and depreciation of equipment whose purchase expense was capitalized. Report amortization of financing costs, leasehold improvements, good will, and similar assets, if present.

Report interest on debt used to finance the development or purchase of the nursing home or the purchase of other capitalized assets. (Report interest on any borrowings for *operating* purposes in "Administration & General.")

Report taxes on real property and on any other capitalized assets subject to a personal property or similar tax. Report the expense of fire and casualty insurance on plant and equipment. (Report the expense of separate *liability* insurance in "Administration & General.")

Report the rental expense of a leased nursing home or leased site and the rental expense of leased equipment that would normally be subject to a depreciation schedule if owned. (Report the rental expense of minor equipment, which would not normally be capitalized and depreciated, in the appropriate operating expense category, e.g., rental of office equipment in "Administration and General.")