Ohio Department of Health

Application for Certificate of Need

Under Chapter 3701-12 of the Ohio Administrative Code
(For applications submitted on or after September 2, 2013)

Instructions

A. If the reviewability of the activity is in question, a Reviewability Ruling may be requested under Chapter 3701-12, Ohio Administrative Code, prior to submission of an application.

B. The applicant for a Certificate of Need (CON) shall be the entity to whom the Nontransferable CON will be issued.

C. Applications must be submitted on forms approved by the director and provided by the Ohio Department of Health (ODH). These forms can be obtained by contacting the CON program at 614-466-3325 or from the Web site at http://www.odh.ohio.gov.

1. Form (pages 1 through 27 and Exhibits): This required information shall be submitted on the approved form using three-hole-punched paper. No changes in the page numbering scheme are permitted.
2. Narrative questions: Begin with page 28 and number the succeeding pages consecutively. In answering the narrative questions, retype each question, then provide the response. Responses must be double spaced using a font no smaller than 10-point.
3. Exhibits: Attach exhibits sequentially, consistent with the Directory of Exhibits, following the narrative responses.

D. A valid application includes:

1. An application as described above in paragraph C. The application must include:
   a. A timetable for implementing the project.
   b. A single identified site for the project (designated by plot or parcel number and street address, if one has been assigned) at the time of submission. The applicant shall not change this site following submission of the application, except in accordance with Section 3702.523 of the Ohio Revised Code.
   c. A designated authorized representative of the applicant.
   d. Proper signature, date and notary seal on the affidavit page.
2. One original application form, attachments and other materials sent by certified mail or hand delivered to:

   Ohio Department of Health
   Division of Quality Assurance
   Certificate of Need Program
   246 North High Street
   Columbus, Ohio 43215

   Once it is filed, the CON application and all information contained therein, including attachments, become a public record and must be compliant with the Health Insurance Portability and Accountability Act (HIPAA).
4. An application fee in the form of a check or money order, payable to the Treasurer—State of Ohio, in the following appropriate amount: the greater of $5,000 or 1.5 percent (.015) of the reviewable portion of the capital expenditure proposed with a maximum fee of $20,000.

E. All applicants filing a CON application must provide the ODH with documentation verifying the status of the applicant.

1. If the applicant is an Ohio corporation, the required documentation is a Certificate of Good Standing issued by the Secretary of State within 60 days prior to application filing.
2. If the applicant is a partnership, the required documentation is a written statement attesting to the existence of the partnership signed by all partners.
3. If the applicant is a limited liability company, the required documentation is a copy of the articles of organization filed with the Secretary of State.

F. Up until the application is declared complete the applicant may change the project site identified in the application (plot or parcel number) by filing a revised CON application in accordance with Section 3702.523 of the Ohio Revised Code.

G. For applications not under a comparative review process, the completeness review period will not commence until ODH has received the valid application. Within 30 days after receipt of a valid application, ODH shall determine whether the application is "complete" (i.e. ready to enter the review cycle) or "incomplete" (i.e. additional information is required). Written questions will be forwarded to the applicant in the case of an incomplete application. Failure by the applicant to respond to questions within 90 days shall result in the application being deemed incomplete. When ODH has received the applicant's answers, a review of the material and assessment of the project's "completeness" status will be made. This process will take a maximum of 30 calendar days. ODH may make two requests for additional information. Failure by the applicant to adequately and completely provide the information necessary to complete the application following these two requests shall result in the application being deemed incomplete.

   For applications under a comparative review process, the completeness review period shall be in accordance with rule 3701-12-09 of the Administrative Code.

H. Applicants whose projects are declared complete shall provide notice in a newspaper of general circulation published in the municipal corporation, county or other political subdivision where the activity will take place within seven business days after the notice of completeness is received. The applicant shall provide a copy of the published notice to the director by certified mail within five business days after the day the notice is first published. If the newspaper notice is not provided within the time frame specified, the applicant shall document in writing why the time frame was not met. The notice shall include:

   1. The date the review period began (i.e. the date the application was declared complete).
   2. The date the decision on the application is due.
   3. The procedure for filing comments concerning the application.
   4. A general description of the nature of the project, which shall include its cost, and the facilities involved in the project.
   5. The street address or plot or parcel number that the project will take place.

I. Applicants whose projects are declared complete may not make any amendment of the application that alters the site, the activity's scope or cost or make any revisions of information filed prior to the notice of completeness. This does not prohibit supplementing an application with clarifying information after the notice of completeness.

J. For applications not under a comparative review process, the CON shall be granted or denied within 60 days after the date of mailing of the notice of completeness.

   For applications under a comparative review process, the CON shall be granted or denied by April 30 or the next business day of the year following the year in which the application is received.

K. Applicants whose projects are granted a CON by the ODH are not relieved of the responsibility for meeting requirements under other federal, state or local laws applicable to their project such as zoning, construction codes and safety, licensure, certification, etc., and are required to maintain substantial accordance with the approved project for five years after completion.

L. Chapter 3702., Ohio Revised Code, and Chapter 3701-12, Ohio Administrative Code, govern the review of CON applications.

M. Consultants within the CON office will be assigned the review of the application and are available to discuss projects at 614-466-3325.

Application for Certificate of Need

Chapter 3701-12 of the Ohio Administrative Code

PART A

1.0 Identification

Name of proposed/existing facility			
Plot or parcel number and street address, if assigned		Telephone ( )	
City	State	ZIP	County
Operator of proposed/existing facility		Relationship of operator to applicant	
Legal name of project applicant			
Street address		Telephone ( )	
City		State	ZIP
Name of owner/board chair/president of applicant		Telephone ( )	
Person completing application		Telephone ( )	
Person to receive all correspondence		Title	
Street address		Telephone ( )	FAX
City		State	ZIP / Email address

For ODH use only

ODH file number	Date application received	Amount of check	Project cost
	/ /	$	$

Application type for bed relocation projects (Check only one)

- ☐ Intra-county bed relocation (A) (May file at anytime).
- ☐ Contiguous county bed relocation (C) (May file at anytime).
- ☐ Comparative review: inter-county bed relocation (X) (May only file in July 2016 and every 4 years thereafter).
- ☐ Comparative review: redistribution of surrendered beds (R) (May only file in July 2014 and every 4 years thereafter).
- ☐ Other reviewable activity (M)

Brief description of project (Identify each source facility, the county and the number of beds proposed to be relocated from each source facility and whether the beds will be placed in a new nursing home, addition to an existing nursing home, existing nursing home or converted space).

Signature of applicant or authorized representative	Date
Typed name of applicant or authorized representative	Title

Applicant Information and Affidavit

Type of applicant (check one)

- ☐ For-profit corporation
- ☐ Not-for-profit corporation
- ☐ Nonprofit association
- ☐ Individual
- ☐ Partnership
- ☐ Limited liability company
- ☐ Government unit (specify)_____
- ☐ Other (specify)_____

Documentation verifying the status of the applicant must be attached in Exhibit L. For example, for a corporate applicant, this documentation is a Certificate of Good Standing issued by the Ohio Secretary of State within the 60 days before the date of application. For an applicant that is a partnership, a written statement attesting to the existence of the partnership signed by all partners should be attached. For an applicant that is a limited liability company, a copy of the articles of organization filed with the Ohio Secretary of State.

Affidavit

State of Ohio

:ss

County of _____

_____ being duly sworn and cautioned according to law,
(applicant or authorized representative)

hereby depose and say that I/we have authorized _____ to submit this application on my/our behalf. I/we further depose and say that to the best of my/our knowledge, the information contained in this application and any accompanying material is true and accurate.

Signature _____ Title _____

Sworn to before me and subscribed in my presence this_____ day of _____,

in the year_____, at _____.

_____
Notary Public

Reviewable Project Costs

2.0 Site/Construction/Renovation

Site

2.11 Land cost $

2.12 Site improvement (grading, utilities, landscaping) $

2.13 Total land cost and site improvement (line 2.11 + line 2.12) $

Construction

2.21 New construction cost
(include fixed equipment in major construction contract) $

2.22 Depreciable life years

2.23 New construction area gross square feet

2.24 Cost per square foot $ (line2.21/line2.23)

2.25 Fixed equipment cost[1] (not included in line 2.21)
List on a separate sheet all items involving an individual capital expenditure of $20,000 or more. Group all less expensive equipment as other fixed equipment and treat as one item. $

2.26 Average depreciable life years

2.27 Total new construction cost (line 2.21 + line 2.25) $

Renovation/Addition

2.31 Renovation or addition cost
(include fixed equipment in major construction contract) $

2.32 Depreciable life years

2.33 Renovation area gross square feet

2.34 Cost per square foot $ (line2.31/line2.33)

2.35 Addition area

2.36 Cost per square foot $

2.37 Fixed equipment cost[1] (not included in line 2.31)
List on a separate sheet all items involving an individual capital expenditure of $20,000 or more. Group all less expensive equipment as other fixed equipment and treat as one item. $

2.38 Average depreciable life years

2.39 Total renovation or addition cost (line 2.31 + line 2.35) $

[1] Fixed equipment—Equipment that is permanently attached to the building or to the electrical, plumbing or ventilation system (i.e. ceiling, wall, floor or table mounted equipment, elevators, etc.).

3.0 Moveable equipment

3.11 Major moveable equipment cost[2] (list each item and its cost on a separate sheet) $

3.12 Average depreciable life ____ years

3.13 Other moveable equipment cost $

3.14 Average depreciable life ____ years

3.15 Total moveable equipment cost (line 3.11 + line 3.13) $

[2] Major moveable equipment means equipment that can be easily detached or unplugged from the electrical, plumbing or ventilation system and involves an individual capital expenditure of $20,000 or more.

4.0 Leasing

Land lease

4.11 Fair market value $

4.12 Term of lease ____ years

4.13 Annual cost[3] $

4.14 Life lease cost $ (line 4.12 x line 4.13)

4.15 Interest rate[4] ____ %

Building lease

4.21 Fair market value $

4.22 Term of lease ____ years

4.23 Annual cost[3] $

4.24 Life lease cost $ (line 4.22 x line 4.23)

4.25 Interest rate[4] ____ %

4.26 Asset life[5] ____ years

4.27 Salvage value $

Equipment lease

4.31	Fair market value		$
4.32	Term of lease		years
4.33	Annual cost[3]	$	
4.34	Life lease cost	$	(line 4.32 x line 4.33)
4.35	Interest rate[4]		%
4.36	Asset life[5]		years
4.37	Salvage value	$	

Bed operating rights lease

4.41	Fair market value		$
4.42	Term of lease		years
4.43	Annual cost[3]	$	
4.44	Life lease cost	$	(line 4.42 x line 4.43)
4.45	Interest rate[4]		%

Total lease value

4.51	Total fair market value (lines 4.11 + 4.21 + 4.31 + 4.41)	$

[3] Annual cost should include rental payment, property tax and any items specified in the lease such as payments required for failure to renew or extend the lease, bargain purchase option payments, etc.

[4] Interest rate should be the lessor's implicit interest rate (rate of return on the leased property). If this is unknown, the applicant's incremental borrowing rate should be provided.

[5] Asset life should be the expected useful life of the asset.

5.0 Total project cost

5.11	Site cost (from line 2.13)	$
5.12	New construction cost (from line 2.27)	$
5.13	Renovation or addition cost (from line 2.37)	$
5.14	Contingency	$
5.15	Construction supervision	$
5.16	Architectural/engineering cost	$
5.17	Planning	$
5.18	Financing cost (exclude debt service reserve fund)	$
5.19	Interest during construction (net)	$
5.20	Other site, construction or renovation costs (specify on a separate sheet)	$
5.21	Total site, construction and renovation/addition cost (add lines 5.11 through 5.20)	$
5.22	Total moveable equipment cost (from line 3.15)	$
5.23	Total fair market value of leased assets (from line 4.51)	$
5.24	Un-depreciated balance of existing/converted space for project use	$
5.25	Professional fees	$
5.26	Acquisition cost for long-term care beds (if applicable)	$
5.27	Other cost (specify on a separate sheet)	$
5.28	Project cost without CON application fee (add lines 5.21 through 5.27)	$
5.29	CON application fee [(.015 x line 5.28) / .985] (minimum of $5,000, maximum of $20,000)	$
5.30	**Total project cost** (line 5.28 + line 5.29)	$

6.0 Associated costs

(Costs incurred in financing or implementing the project which are not included in the total project cost.)

6.11	Debt service reserve fund	$
6.12	Existing debt refinanced with project	$
6.13	Non-reviewable costs (specify on a separate sheet) (include costs of non-reviewable activities to occur at the same site in conjunction with the reviewable activity)	$
6.14	Other (specify)	$
6.15	Total associated costs	$
6.16	Total project and associated costs (line 5.30 + line 6.15)	$

7.0 Source of funds

Equity		**Project**	**Associated**	**Total**
7.11	Philanthropy	$	$	$
7.12	Public funds	$	$	$
7.13	Cash	$	$	$
7.14	Negotiable securities	$	$	$
7.15	Other equity contribution (specify on a separate sheet)	$	$	$
7.16	Total equity (add lines 7.11 through 7.15)	$	$	$
Debt				
7.17	Tax exempt bonds	$	$	$
7.18	Loan	$	$	$
7.19	Other debt (specify on a separate sheet)	$	$	$
7.20	Total debt (add lines 7.17 through 7.19)	$	$	$
Lease/non-capital outlay				
7.21	Total fair market value of lease	$	$	$
7.22	Un-depreciated balance (existing/converted space)	$	$	$
7.23	Other non-capital outlay (specify on a separate sheet)	$	$	$
7.24	Total lease/non-capital outlay	$	$	$
7.25	**Total source of funds** (lines 7.16 + 7.20 +7.24)	**$** equal line 5.30	**$** equal line 6.15	**$** equal line 6.16

8.0 Timetable for completion of the project

(complete in months from the date of approval)

8.11	Acquire site		Months
8.12	Approve zoning		Months
8.13	Complete working design drawings		Months
8.14	Secure financial agreement if externally financed		Months
8.15	Obtain Board of Directors' approval if internally financed		Months
8.16	Execute construction contract		Months
8.17	Secure building permit		Months
8.18	Commence construction/renovation[6]		Months
8.19	Execute lease agreement		Months
8.20	Bill of sale for bed operating rights		Months
8.21	Complete construction		Months
8.22	Secure occupancy permit		Months
8.23	Available for service		Months
8.24	Close source facility or beds		Months

[6] Commencement of construction means the following:

1) For project involving new construction, the placement of any structural foundation element that becomes an integral part of the structure. A structural foundation element includes, but is not limited to, footings, piers, grade beams and infrastructure items such as pilings and caissons. The acts of surveying, staking, soil testing, demolition of existing structures, delivery of materials, establishment or connection of utility services, elimination or removal of a safety or sanitary hazard from the site and site preparation, including site grading, site filling or clearing, are not considered commencement of construction.

2) For projects requiring substantial renovations to an existing structure, the modification or removal of an integral part of the structure or portion thereof. Such modification or removal includes, but is not limited to, the modification or removal of walls and ceilings, large surface replastering, major plumbing projects, and window replacement. Minor repair and maintenance activities that minimally disrupt building components, such as minor electrical and plumbing activities, are not considered commencement of construction.

3) For projects involving an addition, see 1).

9.0 Ownership and Control Interest Disclosure Statement

The following information is required to fully disclose the organization and individuals applying for a Certificate of Need, regardless of intent to participate in reimbursement programs.

General information
Ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as the applicant for Certificate of Need.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity that is held by any other entity and is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the disclosing entity, B's interest equates to 4 percent indirect ownership interest and need not be reported. If the ownership interest is a result of mortgage, deed of trust, etc., please so indicate.

9.11 Answer the following questions by checking "yes" or "no." If any of the questions are answered "yes," list names and addresses of individuals or corporations on an attached sheet.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the disclosing entity (the applicant) that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX or XX of the Social Security Act, 349 Stat. 620 (1935) as amended?

Yes No

B. Are there any directors, officers, agents or managing employees of the disclosing entity (the applicant) who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX or XX of the Social Security Act, 349 Stat. 620 (1935) as amended?

☐ Yes ☐ No

If you need additional space for any of the following items, attach a separate sheet and clearly indicate which item is being continued. If more than one individual is reported and any of the persons named are related to each other (i.e. spouse, child, parent, sibling), this must be reported and should be indicated on the form.

9.12 Ownership interest in the applicant

List names and addresses of individuals or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5 percent or more (principal participants) in the disclosing entity (the applicant). Indirect ownership interest is ownership interest in an entity that has an ownership interest in the disclosing entity. Ownership in any entity higher in the chain of control than the disclosing entity constitutes indirect ownership. If an organization is listed in the table below, also provide individual information for that organization on a separate sheet.

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

9.13 If the disclosing entity (the applicant) is a corporation, list names, addresses and titles of the officers and directors.

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

9.14 If the disclosing entity (the applicant) is a subsidiary of a parent entity, list, in order, all entities within the chain of control of the applicant through the parent entity.

Parent
Subsidiary
Subsidiary
Subsidiary
Subsidiary

9.15 List the names of other Ohio nursing homes in which any of the persons identified in section 9.12 or 9.13 above also have an ownership or interest of 5% or more (attach additional sheet if necessary). For each nursing home, during the time the person had an ownership interest in the owner or operator of the nursing home and encompassed by the three most recent standard surveys preceding the filing of this application, identify the number of level H, I, K and L deficiencies cited and the date each citation was given.

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City				County	ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City				County	ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City				County	ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City				County	ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

9.16 Ownership interest in the operator

List names and addresses of individuals or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5 percent or more in the operator identified for the proposed project. Indirect ownership interest is ownership interest in an entity that has an ownership interest in the operating entity. Ownership in any entity higher in the chain of control than the operating entity constitutes indirect ownership. If an organization is listed in the table below, also provide individual information for that organization on a separate sheet.

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

Name	Relationship to applicant		Percent of ownership interest %
Address	City	State	ZIP

9.17 If the operator identified for the proposed project is a corporation, list names, addresses, and titles of the officers and directors

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

Name	Title	
Address	Telephone ( )	
City	State	ZIP

9.18 List the names of other Ohio nursing homes in which any of the persons identified in section 9.16 or 9.17 above also have an ownership interest of 5% or more (attach additional sheet if necessary). For each nursing home, during the time the person had an ownership interest in the owner or operator of the nursing home and encompassed by the three most recent standard surveys preceding the filing of this application, identify the number of level H, I, K and L deficiencies cited and the date each citation was given.

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City			County		ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City			County		ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

Name of nursing home					Date interest acquired
Address					Type ☐ Ownership ☐ Operation
City			County		ZIP
Citation level **H**	# of citations	Date of citation(s)	Citation level **I**	# of citations	Date of citation(s)
Citation level **K**	# of citations	Date of citation(s)	Citation level **L**	# of citations	Date of citation(s)

9.19 During the 60 months preceding the filing of the CON application, was notice of proposed licensure revocation (including proposed revocation for failure to pay licensure renewal fees) issued for the existing nursing home in which beds are being placed or a nursing home owned or operated by the applicant or a principal participant?

☐ Yes ☐ No

If yes, identify the name and address of the facility and explain:

9.20 List individuals or organizations to which the disclosing entity (the applicant) is financially obligated.

Individual/organization		Telephone ( )	
Address	City	State	ZIP

Individual/organization		Telephone ( )	
Address	City	State	ZIP

Long-term Bed Capacity

Proposed/Existing Facility in Which the Reviewable Activity Will Take Place (Receiving Facility)

Receiving facility

Current status

Bed type	Total beds	Medicaid-certified beds	Medicare-certified beds	Beds not certified
Licensed long-term care beds				
County home beds				
Hospital registered long-term care beds				
Hospital registered skilled nursing beds				
Licensed residential care facility beds				
Alternate living beds				
Other beds (specify)				

After project

Bed type	Total beds	Medicaid-certified beds	Medicare-certified beds	Beds not certified
Licensed long-term care beds				
County home beds				
Hospital registered long-term care beds				
Hospital registered skilled nursing beds				
Licensed residential care facility beds				
Alternate living beds				
Other beds (specify)				

(Note: The rows do not add across to equal total beds.)

Long-term Bed Capacity

Facility from which beds are being relocated (Source facility)

Submit a separate sheet for each facility from which beds are being relocated pursuant to this application.

Source facility

Current status

Bed type	Total beds	Medicaid-certified beds	Medicare-certified beds	Beds not certified
Licensed long-term care beds				
County home beds				
Hospital registered long-term care beds				
Hospital registered skilled nursing beds				
Licensed residential care facility beds				
Alternate living beds				
Other beds (specify)				

After project

Bed type	Total beds	Medicaid-certified beds	Medicare-certified beds	Beds not certified
Licensed long-term care beds				
County home beds				
Hospital registered long-term care beds				
Hospital registered skilled nursing beds				
Licensed residential care facility beds				
Alternate living beds				
Other beds (specify)				

(Note: The rows do not add across to equal total beds.)

Construction/Renovation Cost Data

Each applicant shall complete in detail the cost data form listed below. Where no work is to be done in an area or category, insert a (–). Scope of work shall be listed as "**N**" for new construction and "**R**" for renovation work**.**

Space	Gross square feet	Scope of work
Administration		
Dietary		
Dining		
Recreation		
Employee facilities		
General circulation		
Housekeeping		
Resident units		
General bathing		
Laundry		
Mechanical		
Physical therapy		
Storage		
Unassigned		
Unfinished		
Other (specify)		
Other (specify)		
Other (specify)		
Total		

(Note: Total gross square feet must be equal to lines 2.23 + 2.33 on page 5)

Narrative

PART B

The Ohio Department of Health shall utilize the following narrative questions, corresponding to the general and special review criteria, when conducting certificate of need reviews. All applicants shall address questions 10.1 to 10.46 completely unless a question is clearly not applicable in which case the response should include a brief explanation of why it is not applicable. Applicants filing under a comparative review process shall also address questions 10.47 to 10.60. Responses should correspond, by number, to the question and be submitted in typed, double-spaced form. All pages of the narrative must be numbered beginning with page number 28.

Description

10.1 Provide a brief executive summary of the proposed project that highlights the most salient points described in the detailed narrative responses to the general and special review criteria. This description should contain direct statements that:

- Identify the facilities involved (including addresses);
- Explain what is being proposed (including the number of beds and counties involved);
- Identify how the beds are being acquired (e.g., purchase, lease, intra-company transfer at no cost, etc.);
- Identify the physical space that will accommodate the beds (e.g., construction of a new nursing home, construction of an addition to an existing nursing home, renovations to existing nursing home space, conversion of residential care facility space, etc.); and
- Identify the need and how the proposed project will meet that need.

10.2 For projects that involve any new construction, renovation or addition:

a. Provide a general overview of the work to be done;

b. Discuss the methods and type of construction;

c. Discuss any energy conservation features;

d. Attach as **Exhibit A(1)** copies of local zoning and sewage approvals, if either is required. If approvals have not been issued, identify how the proposed site is currently zoned, efforts that have been undertaken to secure approval, and explain the reasons for the delay;

e. Attach as **Exhibit A(2)** evidence of the applicant's control of the site (e.g., deed, agreement to purchase, etc.);

f. For projects in which beds are being relocated to an existing nursing home:

1) Identify all life safety code violations. If none, specify that there are no life safety code violations;

2) Identify all state fire code violations. If none, specify that there are no state fire code violations. Attach as **Exhibit A(3)** a copy of the most recent state fire marshal report;

3) Identify all state building code violations. If none, specify that there are no state building code violations. Attach as **Exhibit A(4)** a copy of the most recent occupancy permit; and

4) If any such violation exist, state whether this project proposes to correct all such violations.

g. Attach as **Exhibit A(5)**, legible schematic drawings for the entire receiving facility for all existing and proposed (new or converted) long-term care areas. If the facility includes other bed types in the same building as long-term care beds, identify those areas as well. All major areas should be clearly labeled and the net square footage of the area identified. The drawings should include a site plan that corresponds to the site identified in section 1.0 of the application. Drawings must clearly identify the following:

- All long-term care resident rooms with the number of beds in each room and square footage of each room, exclusive of the toilet room;
- All private toilet rooms with a shower or bathtub indicated;
- All common bathing areas;
- All dining areas with square footage; and
- All recreational areas with square footage.

Need

10.3 In planning for this project:

a. Discuss the planning process that preceded submission of this application and the project's relationship to the applicant's long-range plan; and

b. Identify any agencies, organization, groups or individuals that provided consultation or other input. Identify the impact of the input where appropriate.

10.4 Identify each factor which supports the need for the proposed project. List each factor and discuss each separately.

10.5 Discuss the applicant's and all principal participant's historical experience in serving the health related needs of medically underserved groups (e.g. low income, individuals with disabilities, minorities, etc.) and how the proposed project will serve these individuals.

10.6 Service area:

a. Identify the current and projected primary and secondary service area by ZIP code and city, township, etc. for the receiving facility and for each source facility. Indicate where service areas overlap. The primary service area should include contiguous ZIP codes providing 75–80 percent of residents. The secondary service area should include those proximate ZIP codes, excluding isolated outliers, that provide the remaining residents;

b. Quantify the current and projected population in both the projected primary and secondary service areas. Pay particular attention to the age cohorts most apt to require the proposed services, for instance the population aged 65 and over for nursing home services;

c. For intra-county bed relocations only, provide maximum distance and travel times from within the primary and secondary service areas separately to the project site;

d. For intra-county bed relocations only, provide approximate distance and travel time from each source facility to the project site;

e. If portions of the proposed service area are in excess of one hour travel time from the project site, document the reasons for including it within the service area;

f. For the receiving facility and each source facility, provide current and projected resident origin data, by ZIP code. For existing providers, the number of residents originating from each of the ZIP code areas and the percentage of total residents each area represents should be provided;

g. If either the projected service area or the projected resident origin data are expected to change from the current situation, discuss the specific reasons for this change;

h. Discuss any special needs and circumstances of the applicant or population proposed to be served by the proposed project, including prevalence of a particular disease, unusual demographic characteristics, cost-effective contractual affiliations and other special circumstances that are pertinent to this project; and

i. Discuss any special needs related to any research activities, such as participation by the applicant in research conducted by the United States Food and Drug Administration or clinical trials sponsored by the National Institute of Health that will be conducted as a result of implementation of this project.

10.7 Identify all providers within the receiving facility's primary and secondary service areas providing services similar to the proposed project. Discuss the projected impact of the project on each concerning utilization, market share and financial status.

10.8 Attach as **Exhibit B** a legible map which clearly identifies the following:

- ZIP code areas;
- Cities, townships, etc.;
- Major highway systems;
- The primary and secondary service area of the receiving facility;
- The project site;
- Each source facility within the receiving facility's primary and secondary service areas; and
- All other facilities that provide services similar to the proposed project within the receiving facility's primary and secondary service areas.

10.9 Discuss the alternatives to this project. For each alternative, identify the advantages and disadvantages, the cost and the reasons they were not chosen.

Utilization

10.10 Discuss the historical and projected utilization of the receiving facility and each source facility:

a. Use the provided **Exhibit C** to list utilization statistics for the receiving facility for the past two years, current year and for the first three years following project completion. Identify the corresponding calendar year for each column. Complete a separate form for each source facility;

b. Discuss the specific reasons for increases and decreases in the various categories; and

c. Identify the methodology used to project utilization.

10.11 Identify the dollars of care provided and the percentage this represents of the total dollars of care provided by the facility for Medicare, Medicaid and charity care (excluding bad debt) for the past two years, current year and projected for the first three years following project completion.

Financial

10.12 Discuss the availability of funds for the project:

a. For projects involving equity contribution, identify the specific source of these funds and document their availability. For an existing entity, sufficient liquid assets coupled to stockholder's equity (fund balance) should appear on the balance sheet of the applicant. For a new entity, sufficient funds held by the applicant to meet the equity contribution and working capital needed for startup should be documented. Further assurance that the funds will remain available at the time the project is undertaken must also be provided;

b. For projects involving debt financing, provide a copy of the secured financial agreement. If not available, provide documentation from the financial institution evidencing, at a minimum, their review of the proposal and willingness to accept an application for financing. Address the following for each debt vehicle to be used:

- Type;
- Amount of total debt;
- Interest rate;
- Life of loan;
- Security type and amount of required reserves (e.g., debt service reserve fund);
- Capitalized financing costs;
- Continuing financing costs (e.g., insurance premiums);
- Special features (e.g., balloon payments, prepayment restrictions, restrictions on additional debt);
- Bond rating (existing issues);

c. For projects involving lease financing, provide a copy of the lease agreement and any other related agreements with the lessor. If not available, provide documentation of lessor's review of the proposal and willingness to enter into the lease agreement. Indicate whether the lease is a capital lease or operating lease, as determined by FASB 13. Address the following for each lease:

- Type;
- Cost if purchased (fair market value);
- Lease term;
- Interest rate (lessor's implicit interest rate, e.g., rate of return if available, otherwise applicant's borrowing rate);
- Annual rental;
- Annual property tax cost;
- Other costs, such as buyout option payment, penalty for failure to renew lease, etc.;
- Useful life;
- Salvage value;
- Buyout option;

d. For projects involving philanthropy, including fund raising, discuss the applicant's and principal participant's fund raising ability, describing past experiences, community standards for returns from pledges, competition from others for donations and community economic environment; and

e. For projects involving public funds, describe any taxes, governmental grants or other public funds being used and provide terms.

10.13 Attach as **Exhibit D** operating statements for the past two years, current year and for the first three years following project completion both with and without the proposed project for only the licensed nursing home portion of the facility:

a. Revenues should be identified to include, at least, the following:

- Patient days by pay source;
- Total revenue by pay source;
- Other revenue;

b. Expenses must identify direct and indirect expenses; and

c. Additional operating statements may be provided which include other services provided at the facility (e.g., residential care facility beds, alternate living beds).

10.14 Use the provided **Exhibit E** to identify cost and payment rates for the receiving facility and for each source facility. These figures must be reconciled with operating statements provided. Explain the reasons for any increase and decrease between current and projected data. Demonstrate that any increase in costs are reasonable when compared to the benefits achieved from the proposed project.

10.15 Use the provided **Exhibit F** to provide a balance sheet for the receiving facility for the current year and first three years following project completion. Identify the corresponding calendar years and assumptions used in formulating the projections.

10.16 Use the provided **Exhibit G** to provide a cash flow statement for the receiving facility for the current year and first three years following project completion. Identify the corresponding calendar years and assumptions used in formulating the projections.

10.17 Provide copies of the past two years audited financial statements with notes for the receiving facility. No response is necessary if a new facility is being proposed.

10.18 Discuss the historical performance of the applicant and all principal participants in providing cost-effective health care services. Identify the current cost/day and payment rate/day (Medicare, Medicaid, private pay, other) of other nursing homes owned or operated by the applicant or principal participant.

Personnel

10.19 Document that the facility will meet or exceed the staffing requirements for licensure and if applicable, certification (refer to Rule 3701-17-08 of the Ohio Administration Code, Personnel Requirements). Complete **Exhibit H**. Identify the current and projected (by the third year after project completion) number of full- time equivalent (FTE) employees that will be provided to the receiving facility.

10.20 Discuss the availability of qualified personnel to provide the additional staff required and the impact on other area health care providers of recruiting them. Identify the resources available to the applicant for obtaining them.

10.21 Discuss the applicant's and all principal participants', historical compliance with staffing requirements. Identify any citations for staffing deficiencies at the receiving facility in the past three years and remedial action taken. Identify and explain any staffing variances requested for the receiving facility during the past three years. Discuss the historical use of contracted personnel to meet staffing requirements at the receiving facility. Identify the number and type of contracted personnel utilized at this facility within the past two months prior to filing the application.

10.22 If medical or allied health education is an integral aspect of this project, explain specifically how the project will advance this education.

10.23 For projects involving the establishment of a new service or expansion of an existing service, document that the appropriate ancillary and support services are available and discuss the impact of the project of these services. Projects that involve the establishment of a new health care facility must document the availability of the necessary ancillary and support services and whether they will be provided by the applicant or by contractual arrangements.

Administration

10.24 Discuss the experience of the applicant and all principal participants in providing the services proposed. Attach as **Exhibit I** a copy of the most recent accreditation letter from the appropriate accrediting body and documentation of licensure and certification for the receiving facility.

10.25 For each nursing home listed in 9.15 and 9.18 with a level H, I, K or L citation, identify the nursing home, the citation and the date of the citation and, if the deficiencies were attributable to circumstances that arose under a previous ownership or operator, identify what measures have been implemented under the current owner or operator to alleviate the circumstances.

10.26 Identify any action taken within the past three years toward the receiving facility regarding licensure revocation or certification termination.

10.27 Discuss the special needs and circumstances resulting from moral and ethical values and the free exercise of religious rights of health care facilities administered by religious organizations.

10.28 Discuss any impact this project may have on the special needs and circumstances of small rural hospitals and communities and inner city hospitals and communities.

10.29 Identify by facility name, address, county and ODH file number (if known) all other certificates of need granted to the applicant or any principal participant within the past five years and certificates of need that have been granted more than five years ago but have been completed within the past five years. For each approved project, provide a description of the approved activity, identify any deviation from the approved activity, discuss any failure to develop the project in accordance with the approved timetable, and identify any penalties or settlement agreements associated with the approved project.

10.30 Attach as **Exhibit J** copies of any executed agreements for the acquisition of the operating rights to long-term care beds pursuant to this project. State whether there is any dispute over ownership of the operating rights to the beds proposed to be relocated. Provide copies of any other agreements which have been executed pursuant to the bed acquisition.

10.31 Attach as **Exhibit K** documentation verifying the status of the applicant:

- If the applicant is an Ohio corporation, the required documentation is a Certificate of Good Standing issued by the secretary of State within 60 days prior to filing this application;
- If the applicant is a partnership, the required documentation is a written statement attesting to the existence of the partnership signed by all partners;
- Ohio hospitals listed in the Directory of Registered Hospitals do not need to provide this information; and

Special Review Criteria (not previously addressed)
All applicants shall address, as applicable, the special review criteria specified in Rules 3701-12-23 and 3701-12-23.2 of the Ohio Administrative Code.

10.32 State whether the project will comply with the following requirements and identify all areas of the proposed project that will not comply with the following requirements, as applicable:

a. For homes required to be licensed under section 3721 of the Ohio Revised Code, the requirements for licensure under section 3721 of the Ohio Revised Code and chapter 3701-17 of the Ohio Administrative Code; and

b. For hospital long-term care beds, beds in county homes as defined in section 5155.31 of the Ohio Revised Code that are long-term care facilities and long-term care beds in a long-term care facility, the requirements for certification as a nursing facility or skilled nursing facility under title XVIII or XIX of the Social Security Act. 49 stat. 620 (1935), 42 U.S.C. 301, as amended.

10.33 If the project will establish, construct or develop a new long-term care facility, including a replacement facility, other than a hospital that is a long-term care facility, with a long-term care bed capacity of less than 50 beds:

a. Demonstrate that the proposed facility can be operated in a cost-effective manner; and

b. Identify a special health care need to be served that will otherwise not be served and demonstrate the facility's size is essential to serve it or identify a special health care need to be served and demonstrate that the facility's size is in accordance with current evidence-based standards of care; or

c. Demonstrate that the source facility's physical plant is seriously substandard and that the proposed project is the only feasible alternative for cost-effective correction of physical plant deficiencies. Attach as **Exhibit L** reports of building, fire, health or safety inspectors, other adequate documentation or evidence of a restriction on placement of non-ambulatory patients in a portion of the facility; or

d. Demonstrate the proposed facility will be part of a continuing care retirement community or life care community. Document that there is or will be a contractual obligation to provide long-term care services to residents of the community and that residents of the community will be given preference in admission to the long-term care beds.

10.34 If the project will result in a new or replacement long-term care facility with a long-term care bed capacity of more than 150 beds:

a. Demonstrate that the proposed facility can be operated in a cost-effective manner without sacrificing quality of care; and

b. Identify a special health care need to be served that will otherwise not be served and demonstrate the facility's size is essential to serve it.

10.35 State whether the applicant, owner, operator or proposed operator of the receiving facility:

a. Owns the operating rights to the beds being replaced or relocated;

b. Has entered into a contract to acquire the operating rights to the beds being replaced or relocated; or

c. In the case of an application to relocate approved beds, is the holder of the CON for the beds proposed to be replaced or relocated.

10.36 Identify all alternative beds by type that will be eliminated as a result of the proposed project. Identify the plan of care for any residents in the alternative beds who will be displaced as a result of the proposed project.

10.37 Provide a feasible plan for the care of residents served in the beds being replaced or relocated until the new beds are operational and thereafter. At a minimum, this plan must contain assurances that all notice requirements have been or will be met, appropriate coordination with the applicable ombudsman is made and measures designed to mitigate the consequences of relocation have been or will be implemented. Indicate whether long-term care residents being displaced will be permitted to remain in their current facility until the new beds are operational and whether they will be invited to be admitted to the new beds. Identify the procedure for facilitating the availability of the new beds to those residents. Indicate whether the applicant has control over the operation of the source facility. If so, identify the relationship between the applicant and the source facility's operator and if not, indicate how the applicant will be assured that the source facility's operator will carry out the feasible plan for the care of residents identified by the applicant.

10.38 For projects proposing replacement of a facility attach as **Exhibit M** a detailed study of the respective costs that demonstrates that replacement of the source facility is more cost-effective or otherwise more feasible than its renovation. The study shall take into account the useful lives of the respective facilities or document circumstances that otherwise make renovation less feasible.

10.39 Document that the source facility is licensed or otherwise authorized to operate in this state, is staffed and equipped to provide health care services and is actively providing services in all or part of the long-term care beds or that the source facility is licensed or has beds registered as skilled nursing beds or long-term care beds and has provided services in all or part of the long-term care beds for at least 365 consecutive days within the 24 months immediately preceding the date a CON application is filed with the director.

10.40 Discuss the impact of the relocation project on the access of the population served by the source facility with particular reference to geographic access and the availability of Medicaid certified long-term care beds. Demonstrate that access to quality long-term care services particularly for medically undeserved populations will not be impaired.

10.41 Specify whether the proposed project will result in the relocation of long-term care beds across county lines.

Comparative Review Project Criteria

All applicants proposing the inter-county relocation of beds or the redistribution of beds by ODH under a comparative review process in accordance with ORC 3702.593 shall respond to each of the following:

10.42 State whether the beds will serve a medically undeserved population such as low-income individuals or individuals who are members of racial, ethnic, or minority groups. If so, document that each medically undeserved population to be served comprises at least 25% of the population of the defined service area.

10.43 State whether the beds are or will be part of a continuing care retirement community that complies with paragraph (I)(3) of rule 3701-12-23 upon completion of the reviewable activity. If so, identify the total number of alternative beds that are not long-term care beds that are or will be part of the community upon completion of the reviewable activity.

a. Identify the types of alternative beds that are or will be provided.

b. Provide documentation that agreements do or will exist between the long-term care facility and the alternative facility for transfer of residents.

c. If the alternative beds will be constructed in conjunction with the proposed project, certify that the capital expenditure for the alternative beds will be obligated, within the same meaning of paragraph (A)(1)(a) of rule 3701-12-28 of the Administrative Code, at the same time as the capital expenditure for the proposed reviewable activity.

d. Certify that the alternative beds will remain operational for at least two years after the beds are occupied by residents.

e. Certify that if for any reason the alternative beds cannot be developed or provided, development of the portion of the project involving the reviewable activity will be discontinued and the director will be notified immediately.

f. Identify how the alternative beds are or will be integrated into the community system for caring for the elderly and individuals with disabilities.

i. Provide an inventory of existing and projected alternative beds and services within the service area;

ii. Describe the planning process leading to selection of the proposed alternatives;

iii. Provide an analysis of the community need for the proposed alternatives taking into account the needs of the target population, existing and projected alternative beds and services in the community, ability of the target population to pay for the alternatives, and expected impact of the alternatives on utilization of long-term care beds; and

iv. Provide operating statements separately (actual for previous two years and projected for two years) for the alternatives.

10.44 State whether the beds will primarily serve individuals with special health care needs such as traumatic or acquired brain injury, Cerebral Palsy, spinal cord injury or disability, multiple sclerosis, acquired immune deficiency syndrome or other similar conditions. If so, document the need for this service.

10.45 State whether the facility in which the beds will be included will provide alternatives to residential services such as adult day care, home health care, respite or hospice care, and mobile meals. If so, document how each will be provided.

10.46 State whether the health care facility's owner or operator will participate in Medicaid waiver programs for alternatives to institutional care. If so, identify the waiver program and document their ability to participate.

10.47 State whether the project will reduce alternatives to institutional care by converting alternative beds to long-term care. If so, identify the number of alternative beds to be reduced.

10.48 State whether the health care facility in which the beds will be placed is located within the service area of a hospital and is or will be designed to accept patients for rehabilitation after an in-patient hospital stay. If so, document the need for this service.

10.49 State whether the facility in which the beds will be placed has fewer than 50 long-term care beds.

10.50 State whether the facility in which the beds will be placed is or proposes to become a nurse aide training and testing site.

10.51 Document the results of resident and family satisfaction surveys at the existing facility in which the beds will be placed.

10.52 Identify the rating, under the centers for Medicare and Medicaid services' five star nursing home quality rating system, of the health care facility in which beds will be placed.

10.53 Identify any existing community resources within the service area that are serving elderly or individuals with disabilities and discuss the impact of these services on the utilization of long-term care beds at the receiving facility.

All applicants proposing the inter-county relocation of beds under a comparative review process must respond to each of the following:

10.54 Identify each source facility and indicate whether it is located in an area designated by the United States secretary of health and human services as a health professional shortage area under the "Public Health Service Act". If so, identify the projected population aged 65 and over for the census tract and all long-term care facilities (including hospitals with long-term care beds) within the census tract of the source facility. If not, identify the projected population aged 65 and over within a 15 mile radius of the source facility and all long-term care facilities (including hospitals with long-term care beds) within that radius. Project the population for the year during which the relocation of the long-term care beds will take place.

10.55 Provide a certification in **Exhibit N** from each source facility that, upon completion of the proposed project, the operating rights to at least 10% of the number of beds being relocated to another county will be surrendered to the director by de-licensing if the beds are licensed, de-certifying if the beds are certified, and de-registering if the beds are registered.

Exhibit Directory

Exhibit	Document
A (1)	Zoning and sewage approvals
A (2)	Site control
A (3)	State Fie Marshal report
A (4)	Occupancy permit
A (5)	Design drawings
B	Map
C	Bed utilization
D	Operating statements
E	Cost per day and payment rates
F	Balance sheet
G	Cash flow statement
H	Staffing
I	Accrediation, licensure, certification
J	Bed operating rights
K	Status of applicant
L	Source facility substandard plant report
M	Source facility renovation cost study
N	Surrendered beds

Exhibit C

Bed Utilization

Complete a separate form for the receiving facility and for each source facility.

Facility name

	Prior two years		Current year	Three years following project completion		
Year						
Number of long-term care beds (include inactive beds)						
LTC occupancy rate for number of beds above	%	%	%	%	%	%

Occupancy by payer (these must equal 100%)

Medicare	%	%	%	%	%	%
Medicaid	%	%	%	%	%	%
Private pay	%	%	%	%	%	%
Other (specify type)	%	%	%	%	%	%

Number of county home beds						
County home occupancy rate	%	%	%	%	%	%

Number of licensed residential care facility beds						
RCF occupancy rate	%	%	%	%	%	%

Number of alternative beds						
Alternative bed occupancy rate	%	%	%	%	%	%

Number of other beds (specify type)						
Other bed occupancy rate	%	%	%	%	%	%

Exhibit E

Cost and Rate Schedule

Complete Section I for the receiving facility and Section II with current information for each source facility for long-term care beds only. Round all figures to the nearest dollar.

Section I

Receiving facility	Current year	Three years following project completion			Three years without the project		
Year							
Cost per day	$	$	$	$	$	$	$

Payment rate per day

Medicare	$	$	$	$	$	$	$
Medicaid	$	$	$	$	$	$	$
Private pay—private	$	$	$	$	$	$	$
Private pay—semi-private	$	$	$	$	$	$	$
Other (specify)	$	$	$	$	$	$	$
Other (specify)	$	$	$	$	$	$	$

Section II

Source facility name				
Year				
Cost per day	$	$	$	$

Payment rate per day

Medicare	$	$	$	$
Medicaid	$	$	$	$
Private pay—private	$	$	$	$
Private pay—semi-private	$	$	$	$
Other (specify)	$	$	$	$
Other (specify)	$	$	$	$

Exhibit F

Balance Sheet

	Current year	Three years following project completion		
Year				
Assets—Current				
Cash	$	$	$	$
Accounts receivable	$	$	$	$
Inventory	$	$	$	$
Prepaid expenses	$	$	$	$
Other (specify)	$	$	$	$
Total current assets	$	$	$	$

Assets—Property/plant/equipment

Land	$	$	$	$
Buildings	$	$	$	$
Equipment	$	$	$	$
Construction in progress	$	$	$	$
Other (specify)	$	$	$	$
Total property/plant/equipment	$	$	$	$

Total assets	$	$	$	$

Liabilities—Current

Notes payable	$	$	$	$
Accounts payable	$	$	$	$
Salary, wage, tax, withholding	$	$	$	$
Accrued expenses	$	$	$	$
Current portion of long-term debt	$	$	$	$
Other (specify)	$	$	$	$
Total current liabilities	$	$	$	$

Liabilities—Long-term debt

Long-term debt	$	$	$	$
Other (specify)	$	$	$	$
Total long-term debt	$	$	$	$

Total liabilities	$	$	$	$

Fund balance	$	$	$	$

Total liabilities and fund balance	$	$	$	$

Exhibit G

Cash Flow Statement

	Current year	Three years following project completion		
Year				
Beginning Balance	$	$	$	$
Inflows				
Cash receipts from residents	$	$	$	$
Debt borrowing	$	$	$	$
Other (specify)	$	$	$	$
Total inflows	$	$	$	$
Outflows				
Operating expenses	$	$	$	$
Equity contribution	$	$	$	$
Debt service payments	$	$	$	$
Other (specify)	$	$	$	$
Capital expenditures:				
Project related	$	$	$	$
Non-project related	$	$	$	$
Other (specify)	$	$	$	$
Total outflows	$	$	$	$
Net cash inflow/(outflow)	$	$	$	$
Ending Balance	$	$	$	$

Exhibit H

Personnel

Service	Current FTEs		Projected FTEs	
	Employed	Contracted	Employed	Contracted
Non-direct care				
Administration				
Nursing				
Administration				
Medical director				
Medical records				
Laundry				
Housekeeping				
Maintenance				
Dietary technician				
Pharmacist				
Other				
Total non-direct care				
Direct care staff				
Registered nurses				
Licensed practical				
State tested nurse aides				
Activities				
Social services				
Physical therapist				
Dietitian				
Other				
Total direct care staff				
Total all staff				

Include Staff to Meet Minimum Requirements for the projected occupancy of the proposed facility during the third year of operation after implementation of the reviewable activity. Include Projected Agency Staff as "Contracted".