



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR A CERTIFICATE OF NEED FOR THE SALE, PURCHASE OR LEASE OF
PART OR ALL OF AN EXISTING HOSPITAL

Certificate of Need applications must be submitted with a fee in accordance with WAC 440-44-030 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 RCW and Rules and Regulations adopted the Department (WAC 248-19) State of Washington. I hereby certify that the statements made in this application are correct to the best of knowledge and belief.

(Purchaser/Leasee)

(Seller/Lessor)

Signature of Chief Executive Officer

Signature of Chief Executive Officer

Telephone

Date

Telephone

Date

Legal Name/Address of Applicant:

Legal Name/Address of Seller/Lessor:

List Names/Addresses and titles of all Principal Officers and all individuals with 10% or more interest in the applicant. (Attach list)

List Names/Addresses and titles of all Principal Officers and all individuals with 10% or more interest in the seller/lessor. (Attach list)

If Purchaser/Lessee is a non-profit organization, list the Names/Addresses of Board of Directors. (Attach list.)

If Seller/Lessor is a non-profit organization, list the Names/Addresses of Board of Directors. (Attach list.)

Proposed Name of Hospital after being acquired:

Name of Hospital to be acquired:

Type of Acquisition: Purchase ()
Lease () ()
(Other specify)

Address of Hospital to be acquired:

Intended date of acquisition:

ESTIMATED CAPITAL EXPENDITURE:

\$

ATTACH NARRATIVE PORTION OF THE APPLICATION

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and one copy of the completed application, with narrative portion to:

**DEPARTMENT OF HEALTH
CERTIFICATE OF NEED PROGRAM
PO BOX 47852
OLYMPIA WA 98504-7852**

The application must be accompanied by a check, payable to: *Department of Health* for the application review fee, based on the project description, as identified on the enclosed fee schedule.

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: \$ _____ (refer to fee schedule)

APPLICANT NAME: _____

DATE OF SUBMISSION: _____ CHECK NUMBER: _____

CERTIFICATE OF NEED FEE SCHEDULE

Effective 7/1/08

Application Fees

An application for a certificate of need under chapter 246-310-990 WAC must include payment of a fee consisting of the following:

- A review fee based on the facility/project type.
- If more than one facility/project type applies to an application, the review fee for each type of facility/project must be included.

Facility/Project Type	Review Fee
Ambulatory Surgical Centers/Facilities	\$17,392
Amendments to Issued Certificates of Need	\$10,961
Emergency Review	\$7,055
Exemption Requests (Non-Refundable Fee)	
• Continuing Care Retirement Communities (CCRCs)/Health Maintenance Organization (HMOs)	\$7,055
• Bed Banking/Conversions	\$ 1,147
• Determinations of Non-Reviewability	\$ 1,639
• Hospice care center	\$ 1,476
• Nursing Home Replacement/Renovation Authorizations	\$ 1,476
• Nursing Home Capital Threshold under RCW 70.38.105(4)(e) (excluding replacement/renovation authorizations)	\$1,476
• Rural Hospital/Rural Health Care Facility	\$1,476
Extensions (Non-Refundable Fee)	
• Bed Banking	\$656
• Certificate of Need/Replacement-Renovation Authorization Validity Period	\$656
Home Health Agency	\$21,001
Hospice Agency	\$18,704
Hospice Care Centers	\$10,961
Hospital (excluding Transitional Care Units-TCUs, Ambulatory Surgical Center/Facilities, Home Health, Hospice, and Kidney Disease Treatment Centers)	\$34,457
Kidney Disease Treatment Centers	\$21,331
Nursing Homes (including CCRCs and TCUs)	\$39,380

Fees for Amending Pending Applications

The fee for amending a pending certificate of need application-is determined as follows:-

- If an amendment to a pending certificate of need application results in the addition of one or more facility/project types the review for each additional facility/project type must accompany the amendment application;
- If an amendment to a pending certificate of need application results in the removal of one or more facility/project types the department shall refund to the applicant the difference between the review fee previously paid and the review fee applicable to the new facility/project type;
- If an amendment to a pending certificate of need application results in any other change as identified in WAC 246-310-100, a fee of \$1,756 must accompany the amendment application.

Refunds

- If a certificate of need application is returned by the department under WAC 246-310-090 (2)(b) or (e), the department shall refund 75% of the review fees paid.
- If an applicant submits a written request to withdraw a certificate of need application before the beginning of review, the department shall refund 75% of the review fees paid by the applicant.
- If an applicant submits a written request to withdraw certificate of need application after the beginning of review, but before the beginning of the ex parte period the department shall refund 50% of all review fees paid.
- If an applicant submits a written request to withdraw an application after the beginning of the ex parte period the department shall not refund any of the review fees paid.
- Review fees for exemptions and extensions are nonrefundable.

APPLICATION INFORMATION INSTRUCTIONS

These application information requirements are to be used in preparing a Certificate of Need application.

The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 78.38.115 and WAC 248-19-328, 370, 380, 390, and 400, and standards contained in the Washington State Health Plan

1. The application is to be submitted together with a completed and signed Certificate of Need application face sheet and the appropriate review and processing fee. Two copies are to be sent to: **Certificate of Need Program**.
2. Submit a copy of the **Letter of Intent** for this project in the application.
3. Please make the narrative information complete and concise. Data sources are to be cited. Extensive supporting data which would tend to interrupt the narrative should be placed in the appendix. Please number **ALL** pages.
4. All cost projections are to be in noninflated dollars. Use the current year dollar value for all proforma data and projections. **Do not** inflate these dollar amounts.
5. Capital expenditures should not include contingencies. Certificate of Need statute and regulations allow a 12% or \$50,000, which ever is greater, margin before an amendment to an approved Certificate is required.

INTERIM
APPLICATION GUIDELINES

I. APPLICANT DESCRIPTION

1. Type of ownership (public, private/corporation, church, proprietary, etc.)
2. Provide the following information about purchaser/lessee.
 - (a) If corporation, attach copies of Corporate Charter, Articles of Incorporation, and chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulation.
 - (b) If partnership, enclose copy of partnership agreement.
3. Is the applicant currently, or does the applicant propose to be reimbursed for services provided under Titles V, XVIII and/or XIX of the Social Security Act?

II. FACILITY DESCRIPTION

1. Description of facility to be acquired:
 - (a) Type of facility
 - (b) Total licensed bed capacity at present.
 - (c) Average number of set-up beds in last 12 months.
 - (d) Scopes and levels of daily nursing and ancillary services presently offered.
2. Identify the primary geographic planning area presently served by the facility to be acquired.
3. Specify the facility's present peer group classification.
4. Provide the facility's overall utilization in inpatient days/years for the last five years.

III. PROJECT DESCRIPTION

1. If the hospital is to be:
 - a. purchased from present owner - attach a copy of the proposed (agreed upon) sale contract or option to purchase executed by the principals.
 - b. leased from the present owner - attach a copy of the proposed (agreed upon) lease agreement.

NOTE: Both the proposed sale contract or option to purchase and/or lease agreement must be contingent upon the purchaser/lessee first receiving either a Certificate of Need or being granted an exemption.

2. As a result of the proposed acquisition, describe the hospital's projected service mix for the first three years following date of acquisition. Identify any changes in service mix by comparing the projected service mix with the service mix prior to date of acquisition.
3. Identify any proposed reductions or eliminations of particular services during the first three years following date of acquisition. For these services describe the nearest available source of those services.
4. Provide a descriptive detail of the benefits, in terms of improved access, availability, cost or structure and process of care that would be realized by the community as the result of this acquisition.
5. If the purchaser in this transaction is purchasing a lease right from the seller, enclose a copy of the assignment agreement which shall be in effect if a Certificate of Need is granted.
6. Provide a detailed description of the total amount of the proposed capital expenditure which must agree with the estimated capital expenditure on the face sheet, including at the least the following:

Site Acquisition Costs

1.1 Land Acquisition Costs	\$ _____
1.2 Fees	\$ _____
1.3 Total Land Costs	\$ _____
1.4 Total Site Improvement (utilities)	\$ _____
1.5 Total Land Acquisition & Site Improvement	\$ _____

Building & Equipment Acquisition Costs

2.1 Building Acquisition Costs	\$ _____
2.2 Fees	\$ _____
Depreciable Life _____	
2.3 Total Building Acquisition Costs	\$ _____
2.4 Fixed Equipment Costs Not Included in Line 2.3	\$ _____
Average Depreciable Life _____	
2.5 Movable Equipment Acquisition Costs	\$ _____
2.6 Fees	\$ _____
2.7 Average Depreciable Life _____	
2.8 Total Building & Equipment Costs	\$ _____

Other Acquisition Costs

3.1 Surveys, tests, etc.	\$ _____
3.2 State Permits, Fees	\$ _____
3.3 Title Transfer/Registration	\$ _____
3.4 State Sales Tax	\$ _____
3.5 Consultant Fees	\$ _____
3.6 Appraisal Fees	\$ _____
3.7 Existing Debt Refinanced with Project	\$ _____
3.8 Other	\$ _____
3.9 Total Other Acquisition Costs	\$ _____
Total Capital Expenditure (line 1.5 + line 2.8 + line 3.9)	\$ _____

Leasing Costs

Land Lease

4.1 Term of Lease _____ years
 4.2 Annual Cost* \$ _____
 4.3 Life Lease Cost (line 4.2 x line 4.1) \$ _____
 4.4 Interest Rate** _____ %
 4.5 Fair Market Value \$ _____

Building Lease

4.11 Term of Lease _____ years
 4.21 Annual Cost* \$ _____
 4.31 Life Lease Cost (line 4.21 x line 4.11) \$ _____
 4.41 Interest Rate** _____ %
 4.51 Fair Market Value \$ _____
 4.61 Asset Life*** _____ years
 4.71 Salvage Value \$ _____

Equipment Lease

4.111 Term of Lease _____ years
 4.211 Annual Cost* \$ _____
 4.311 Life Lease Cost (line 4.211 x line 4.111) \$ _____
 4.411 Interest Rate** _____ %
 4.511 Fair Market Value \$ _____
 4.611 Asset Life*** _____ years
 4.711 Salvage Value \$ _____

Total Fair Market Value \$ _____

*Annual cost should include rental payment, property tax, WA sales 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.

**Interest rate should be the lessor's implicit interest rate (rate of return on his leased property). If this is unknown, the sponsor's incremental borrowing rate should be provided.

***Asset life should be the expected useful life of the asset.

Source of Funds

The amounts from each source of funds should be allocate between project and associated costs as appropriate.

	Project	Associated Costs	Total
5.1 Philanthropy	\$ _____	\$ _____	\$ _____
5.2 Public Funds	\$ _____	\$ _____	\$ _____
Other Equity:			
5.3 Cash	\$ _____	\$ _____	\$ _____
5.4 Negotiable Securities	\$ _____	\$ _____	\$ _____
5.5 Other	\$ _____	\$ _____	\$ _____

	Project	Associated Costs	Total
5.6 Total Other Equity	\$ _____	\$ _____	\$ _____
5.7 Tax Exempt Bonds	\$ _____	\$ _____	\$ _____
Other Debt:			
5.8 Mortgage	\$ _____	\$ _____	\$ _____
5.9 Other	\$ _____	\$ _____	\$ _____
5.91 Total Other Debt	\$ _____	\$ _____	\$ _____
Total Source of Funds	\$ _____	\$ _____	\$ _____

7. Identify and discuss in the context of the Certificate of Need review criteria contained in 70.38.115(2) RCW and WAC 248-19-370, 380, 390, and 400 the reasons that the hospital or part of the hospital is being offered for acquisition or lease. Also, provide a discussion of the possible consequences that would result should a Certificate of Need not be issued.

IV. PROJECT RATIONALE

Provide documentation to establish conformance of this project with applicable review criteria.

A. NEED (WAC 248-19-370)

1. Project the first three years anticipated utilization of the service or services that would be provided by the hospital. Describe the methodology and underlying assumptions used in projecting utilization. This should be expressed in appropriate workload units of measure as required in the Accounting and Reporting Manual for Hospitals of the State Hospital Commission. RVU measures should also be expressed in procedure units.
2. In detail describe the previous policies and practices of the hospital administration with respect to the availability and hours of accessibility of inpatient and outpatient services by those who are low income, members of an ethnic or racial minority, women, and/or elderly. Compare and contrast these former policies and practices on service availability and accessibility to underserved groups, such as low income, members of an ethnic or racial minority, women, and/or elderly. Wherever possible numbers and percentages of total service utilization should be used to substantiate the narrative.

B. FINANCIAL FEASIBILITY (WAC 248-19-380)

1. Provide a market value and replacement cost analysis which includes at least the following: (a) asset cost of lessor or seller, (b) market value, (c) replacement cost, and (d) market value appraisal was made by (person, credential and organization) and date of appraisal.
2. Provide a listing of amount of annual depreciation and average depreciable life used for buildings and fixed equipment, movable equipment, and capitalized leases for: (a) current owner, (b) purchaser's projection.
3. Attach loan amortization schedule, if applicable.

4. Describe the extent to which related organizations are involved in the financing and describe the relationship.
5. Describe all covenants related to the financing of the proposed acquisition, and any existing covenants on outstanding long-term debts of the existing hospital.

Provide the following historical and pro forma financial statements in current year constant dollars.

- (a) Consolidated hospital-wide revenue and expenses statement for each year for three full fiscal years following date of anticipated transaction. Describe in full all input price assumptions for salaries and wages employee benefits, professional fees, supplies, purchased services-utilities, purchased services-other, depreciation and other direct expenses used in the pro forma statements.
 - (b) Pro forma balance sheet, statement of changes in financial position of unrestricted fund, and changes in components of working capital for each year for three full fiscal years following the date of anticipated transactions.
 - (c) Pro forma capital expenditure budgets for each year starting from the first year following last budget submittal to the Hospital Commission up through three full fiscal years following date of anticipated transaction.
 - (d) Consolidated hospital-wide expense and revenue statements for the last three full years and an estimated statement for the current fiscal year.
 - (e) Changes in components of working capital and changes in financial position of unrestricted fund statements for the last three full fiscal years and an estimated statement for the current fiscal year.
 - (f) Balance sheets detailing the assets, liabilities and net worth of the hospital for the last three fiscal years and an estimated statement for the current fiscal year.
6. Provide the following:
- (a) present mix of patients by payer (Medicaid, Medicare, Private Pay) and percentage of each,
 - (b) anticipated number of admissions by payer for the next three full fiscal years following transaction,
 - (c) patient days by type of payer for past three fiscal years and an estimate for the current fiscal year (total patient days for each payer per year),
 - (d) expected patient days by type of payer for the next three full fiscal years (total patient days for each),

- (e) total patient revenues from each payer (Medicare, Medicaid, Private Pay) by year for the past three fiscal years and an estimate for the current fiscal year, and
 - (f) anticipated patient revenues from each payer (Medicare, Medicaid, Private Pay) by year for the first three full fiscal years following the proposed date of the transaction.
7. Provide the following ratios for the previous three fiscal years, current year and the first three full fiscal years following the proposed date of the transaction:
- (a) Total Accumulated Depreciation ÷ Gross Plant, Property and Equipment
 - (b) Total Debt ÷ Total Fund Balance
 - (c) Total Assets ÷ Total Liabilities
 - (d) Total Debt ÷ Net Property, Plant and Equipment
 - (e) Total Debt ÷ Appraised Market Value
 - (f) Current Assets ÷ Current Liabilities
 - (g) (Cash + Marketable Securities + Accounts Receivable) ÷ Current Liabilities
 - (h) Total Operating Revenue ÷ Inventory
8. Identify source(s) and amounts of the initial working capital.

C. STRUCTURE AND PROCESS (QUALITY) OF CARE (WAC 248-19-390)

- 1. Describe the history of the applicant with respect to criminal convictions related to the ownership/operation of a health care facility, licensure revocation, and other sanctions described in WAC 248-19-390(5)(a). If there have been no such convictions or sanctions, so state.
- 2. Describe the working relationships of the hospital with other health facilities which are within the hospital's primary geographic service area. Discuss any new working relationships between the hospital and other health facilities which are within the hospital's primary geographic service area which would be developed as a result of this project.

D. COST CONTAINMENT (WAC 248-19-400)

- 1. Identify and document all alternative means of acquiring this hospital which were explored. Provide an analysis of each alternative which should include at least the capital costs, financing costs and operating costs per adjusted patient day during the first three full fiscal years following date of acquisition.

2. In constant dollars provide total operating expenses per adjusted patient day and adjusted admission, and total rate setting revenues per adjusted patient day and adjusted admission starting from the last three full fiscal years, estimates for the current fiscal years, and projections for the first three full fiscal years following the date of the anticipated transaction.