Certificate of Need Program
P.O. Box 47852
Olympia, Washington 98502-7852

Lease of Part or All of a Hospital
Project Specific Criteria
Reminder: Follow application instructions

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

DOH 260-074 May 2025

A. Community Need

1. Describe the benefits, if any, to the community that will result from this lease. This description must include the following:
   a. Access to care
   b. Availability of services
   c. Costs
   d. Quality of Care
2. Describe the impact to the community if this project were to be denied.

B. Service Changes

1. Describe any anticipated changes in service during the first three years of the proposed lease.
2. If anticipated changes include a reduction, relocation, or elimination of a service, document the following:
   a. Need the population presently has for the service.
   b. How the need will be adequately met by the proposed change
   c. Alternative arrangements designed to meet the identified need

C. Access to Services

1. Document the manner in which the hospital intends to assure access to services by:
   a. Low income persons
   b. Racial and ethnic minorities
   c. Women
   d. Disabled persons
   e. Other underserved groups
2. Provide the following for the **current** hospital operations:
   a. Copy of the hospital's admissions policy or policies
   b. Copy of the hospital's nondiscrimination policy
   c. Copy of the hospital's community health needs assessment, if applicable
   d. Copy of the hospital's charity care policy. If the hospital has more than one charity care policy based on type of service, provide a copy of all charity care policies.
   e. Copy of the hospital's end of life policy or policies
   f. Copy of the hospital's reproductive health policy or policies
   g. Other information as appropriate
3. Provide the following for the **post lease** hospital operations:
   a. Copy of the hospital's admissions policy or policies
   b. Copy of the hospital's nondiscrimination policy
   c. Copy of the hospital's community health needs assessment, if applicable
   d. Copy of the hospital's charity care policy. If the hospital has more than one charity care policy based on type of service, provide a copy of all charity care policies.
   e. Copy of the hospital's end of life policy or policies
   f. Copy of the hospital's reproductive health policy or policies
   g. Other information as appropriate
4. Charity Care Levels: Lessor's hospital operations:

	Historical Year _____	Historical Year _____	Last full Year _____
Dollar Amount			
% of total Revenue			
% of Adjusted Revenue			

5. Charity Care Levels: Lessee's current operations and project's projected:

	Historical Year ____	Historical Year ____	Last full Year ____	Projection Year 1 ____	Projection Year 2 ____	Projection Year 3 ____
Dollar Amount						
% of total Revenue						
% of Adjusted Revenue						

Financial Feasibility (WAC 246-310-220)

Reminder: Follow application instructions on page 3 of this form

A. Financial Statements

1. Provide a copy of the proposed lease. Include all attachments, exhibits, and appendices.
2. Complete the financial statements in the format provided by the forms at the end of this application.
3. Number of admissions by payor source for past three fiscal years and estimate of current year.

Payor	Historical Year____	Historical Year____	Historical Year____	Current Year Est.
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				
HMO				
Other (Specify)				

4. Patient days by payor source for past three fiscal years and estimate of current year.

Payor	Historical Year____	Historical Year____	Historical Year____	Current Year Est.
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				
HMO				
Other (Specify)				

5. Total patient revenue by payor source for past three fiscal years and estimate of current year

Payor	Historical Year____	Historical Year____	Historical Year____	Current Year Est.
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				
HMO				
Other (Specify)				

6. Projected number of admissions by payor source following lease.

Payor	Partial Year____	Projected Year____	Projected Year____	Projected Year____
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				

Payor	Partial Year____	Projected Year____	Projected Year____	Projected Year____
HMO				
Other (Specify)				

7. Projected number of patient days by payor source following lease.

Payor	Partial Year____	Projected Year____	Projected Year____	Projected Year____
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				
HMO				
Other (Specify)				

8. Projected Revenue by payor source following lease.

Payor	Partial Year____	Projected Year____	Projected Year____	Projected Year____
Medicare				
Medicaid				
Private (no Insurance)				
Insurance-Other				
HMO				
Other (Specify)				

9. Identify source(s) and amounts of the initial working capital.

10. Estimated Start-up and Initial Operating Expenses
    a. Total Estimated Start-up costs (Expenses incurred prior to opening such as staff training, inventory, etc.) $_____
    b. Estimated Period of Time Necessary for Initial Start up: _____"months"
    c. Total Estimate initial operating deficits, if any (Operating deficits, occurring during operating period.) $_____
    d. Estimated initial operating breakeven point (Period of time from receipt of first patient until total revenues equal total expenses.) _____"months"

11. Provide the most recent audited financial statements for the hospital's current operation.

12. Provided the most recent audited financial statements for the lessee's current operation.

C. Project Financing

1. Identify the sources and amounts of project financing.

Source of Financing	Amount
a. Public Campaign	$_____
b. Bond Issue	$_____
c. Commercial Loans	$_____
d. Government Loans	$_____
e. Grants	$_____
f. Bequests and Donations	$_____
g. Private Foundations	$_____
h. Accumulated Reserves	$_____
i. Internal Loans	$_____
j. Capital Allowance	$_____

k. Other – specify $_____

l. **Total** (Should equal Total Project Cost) $_____

2. Describe if any related organizations are involved in the financing of this project. If yes, describe its relationship.
3. Describe all covenants related to the financing of the proposed lease.
4. For projects to be totally or partially funded from capital allowance, identify the amount(s) of capital allowance and budget year(s) during which the funds would be used.
5. Evidence of Availability of Financing for the Project. Submit one of the following:
   a. Copies of letter(s) from lending institutions stating a willingness to finance the proposed project. The letter(s) should include:
      i. Status of loan application(s)
      ii. Purpose of the loan(s)
      iii. Proposed interest rate(s) (Fixed or Variable)
      iv. Proposed term (period) of the loan(s)
   b. Copies of Hospital Board minutes authorizing the proposed project.
6. Provide amortization schedule(s) for each financing arrangement including long-term and any short-term start-up or initial operating deficit loans. Identify the:
   a. Principal
   b. Term (number of payment periods) (long term loans may be annualized)
   c. Interest
   d. Outstanding balance at end of each payment period

Structure and Process-Quality of Care (WAC 245-310-230)

A. Staffing

1. Describe any anticipated changes in hospital staffing as a result of this proposed lease.
2. Describe any anticipated changes in physician privileges, etc. as a result of this proposed purchase.
3. Describe any other anticipated changes not described in 1 or 2 above.

B. Continuity of Care and Unwarranted Fragmentation of Services

1. Describe the working relationships of the hospital with other health facilities **in** the hospital's primary geographic service area.
2. Describe any new working relationships between the hospital and other facilities **in** the hospital's primary geographic service area that would be developed as a result of this project.
3. Describe the working relationships of the hospital with other health facilities that are in **outside** the hospital's primary geographic service area.
4. Describe any new working relationships between the hospital and other facilities **outside** the hospital's primary geographic service area that would be developed as a result of this project.

C. Compliance

1. Identify if the Lessee in this application has had any of the following in this state or other states:
   a. Decertification from Medicare
   b. Decertification from Medicaid
   c. Convictions related to the competency to practice medicine or own or operate a hospital
   d. Denial of a license
   e. Revocation of a license
   f. Voluntary withdrawal from Medicare or Medicaid while decertification processes were pending.

g. Ongoing or completed investigations concerning the operation of any or all of its health care facilities.

2. If yes to any part of question 1, describe the incident and provide clear, sound, and convincing evidence that the occurrence is not likely to re-occur.

Cost Containment (WAC 246-310-240)

1. Identify each option considered before submitting the current application, including no action.

2. For each option identified in question 1, provide at least the following information:
   a. Advantages
   b. Disadvantages
   c. Impact on operating costs to the hospital
   d. Impact on staffing
   e. Impact on costs to the patient
   f. Impact on physical hospital space
   g. Legal restrictions
      i. If lessee or lessor is organizationally connected to a hospital district, provide a discussion of how the lease transaction meets the requirements in RCW 70.44.
   h. Other-Specify
   i. Reason for rejecting each option

3. Identify the specific ways this project will promote staff efficiency and productivity.

4. Identify the specific ways this project will promote system efficiency.