



**C. Financial Information (Please attach additional background material as necessary)**

1. Attach a summary of the estimated facility cost reductions resulting from the proposed temporary decertification or permanent conversion of RHCF beds. Provide an explanation of all assumptions behind the estimates. Include a detailed description and computation of the proposal's cost savings to the Medicaid program.
2. a) Please estimate the anticipated change(s) to the nursing facility's Medicaid reimbursement rate(s) to reflect proposed bed modifications. Explain all assumptions and calculations.

	Current Medicaid <u>Per Diem</u>	Estimated Medicaid <u>Per Diem</u>
Operating Component	\$	\$
Capital Component	\$	\$
<b>Total</b>	<b>\$</b>	<b>\$</b>

- b) If there are project capital costs associated with the proposal, describe fully.
3. Provide the facility's average number of Medicaid eligible bed hold/reserve days for most current three year period

Year	Medicaid Eligible Bed Hold Days

4. Submit first and third year operating budgets to reflect revenues and expenses resulting from the temporary decertification or conversion of beds. Include all pertinent revenue and expense assumptions.
5. Please assess the potential for improving the financial viability of the facility as a result of the requested rightsizing initiative.
6. Include certified financial statements for the last two years.

**D. Programmatic Information (Please attach additional background material as necessary)**

1. Describe the impact of the proposal on quality of care and quality of life for consumers.
2. List the availability and resource of less restrictive/institutional long-term care programs and services in your planning area.
3. Appropriate CON application attached for alternate services requested (Permanent Conversion only)

Yes

No