Rev. 5-13

ALABAMA
CERTIFICATE OF NEED
APPLICATION

For Staff Use Only

Project # _____
Date Rec. _____
Rec. by: _____

INSTRUCTIONS: Please submit an original and two (2) copies and an electronic pdf copy of this form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104.
(Post Office Box 303025, Montgomery, AL 36130-3025)

A filing fee in the amount of $_____ has been submitted with this application. Refer to Rule 410-1-7-.06 of the Certificate of Need Program Rules and Regulations to determine the required filing fee.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

I. APPLICANT IDENTIFICATION (Check One) HOSPITAL (____) NURSING HOME (____)
OTHER (____) (Specify) _____

A._____
Name of Applicant (in whose name the CON will be issued if approved)

_____
Address City County

_____
State Zip Code Phone Number

B._____
Name of Facility/Organization (if different from A)

_____
Address City County

_____
State Zip Code Phone Number

C._____
Name of Legal Owner (if different from A or B)

_____
Address City County

_____
State Zip Code Phone Number

D._____
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

_____
Address City County

_____
State Zip Code Phone Number

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

1. Individual (____)
2. Partnership (____)
3. Corporate (for profit) (____) _____
   Name of Parent Corporation
4. Corporate (non-profit) (____) _____
   Name of Parent Corporation
5. Public (____)
6. Other (specify) (____) _____

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS	GOVERNING BOARD MEMBERS
_____	_____
_____	_____
_____	_____

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

_____ New Facility
Type_____

_____ New Service
Type_____

_____ Construction/Expansion/Renovation

_____ Change in Service

_____ Major Medical Equipment
Type_____

_____ Termination of Service or Facility

_____ Other Capital Expenditure
Type_____

III. EXECUTIVE SUMMARY OF THE PROJECT (brief description)

_____

_____

_____

_____

_____

IV. COST

A. Construction (includes modernization expansion)

1. Predevelopment $_____
2. Site Acquisition _____
3. Site Development _____
4. Construction _____
5. Architect and Engineering Fees _____
6. Renovation _____
7. Interest during time period of construction _____
8. Attorney and consultant fees _____
9. Bond Issuance Costs _____
10. Other _____ _____
11. Other_____ _____

TOTAL COST OF CONSTRUCTION $_____

B. Purchase

1. Facility $_____
2. Major Medical Equipment _____
3. Other Equipment _____

TOTAL COST OF PURCHASE $_____

C. Lease

1. Facility Cost Per Year ____x _____ Years = $_____
2. Equipment Cost per Month
   _____ x _____ Months = _____
3. Land-only Lease Cost per Year
   _____ x _____ Years _____

TOTAL COST OF LEASE(s) $_____
(compute according to generally accepted accounting principles)

Cost if Purchased $_____

D. Services

1. _____ New Service $ _____
2. _____ Expansion $_____
3. _____ Reduction or Termination $_____
4. _____ Other $_____

FIRST YEAR ANNUAL OPERATING COST $_____

E. Total Cost of this Project (Total A through D)
(should equal V-C on page A-4) $_____

IV. COST (continued)

F. Proposed Finance Charges

1. Total Amount to Be Financed $_____
2. Anticipated Interest Rates _____
3. Term of Loan _____
4. Method of Calculating Interest on Principal Payment _____

_____

_____

V. ANTICIPATED SOURCE OF FUNDING

		Amount	Source
A.	Federal		
1.	Grants	$_____	_____
2.	Loans	_____	_____
B.	Non-Federal		
1.	Commercial Loan	_____	_____
2.	Tax-exempt Revenue Bonds	_____	_____
3.	General Obligation Bonds	_____	_____
4.	New Earning and Revenues	_____	_____
5.	Charitable Fund Raising	_____	_____
6.	Cash on Hand	_____	_____
7.	Other	_____	_____

C. TOTAL (should equal IV-E on page A-3) $_____

VI. TIMETABLE

A. Projected Start/Purchase Date _____

B. Projected Completion Date _____

PART TWO: PROJECT NARRATIVE

Note: In this part, please submit the information as an attachment. This will enhance the continuity of reading the application.

The applicant should address the items that are applicable to the project.

I. MEDICAL SERVICE AREA

A. Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11" map indicating the service area and the location of the facility.

B. What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.

C. If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.

D. Are there any other factors affecting access to the project?

(__) Geographic (__) Economic (__) Emergency (____) Medically Underserved

Please explain.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

A. What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?

B. How will the project correct the inadequacies?

C. Why is your facility/organization the appropriate facility to provide the proposed project?

D. Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.

E. If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.

F. Describe the relationship of this project to your long-range development plans, if you have such plans.

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

A. Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.

B. How will the proposed project affect existing or approved services and facilities in the medical service area?

C. Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.

D. Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.

E. List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

A. What alternatives to the proposed project exist? Why was this proposal chosen?

B. How will this project foster cost containment?

C. How does the proposal affect the quality of care and continuity of care for the patients involved?

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT (Attach endorsements if desired)

VI. NON-PATIENT CARE
If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

VII. MULTI-AREA PROVIDER
If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

VIII. HEALTH MAINTENANCE ORGANIZATION
If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

IX. ENERGY-SAVING MEASURES
Discuss as applicable the principal energy-saving measures included in this project.

X. OTHER FACTORS
Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

PART THREE: CONSTRUCTION OR RENOVATION ACTIVITIES
Complete the following if construction/renovation is involved in this project. Indicate N/A for any questions not applicable.

I. ARCHITECT _____

Firm _____

Address _____

City/State/Zip _____

Contact Person _____

Telephone _____

Architect's Project Number_____

II. ATTACH SCHEMATICS AND THE FOLLOWING INFORMATION

A. Describe the proposed construction/renovation

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

B. Total gross square footage to be constructed/renovated_____

C. Net useable square footage (not including stairs, elevators, corridors, toilets) _____

D. Acres of land to be purchased or leased _____

E. Acres of land owned on site _____

F. Anticipated amount of time for construction or renovations _____(months)

G. Cost per square foot $_____

H. Cost per bed (if applicable) $_____

PART FOUR: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects under $500,000.00 and/or those projects for ESRD and home health. If this project is not one of the items listed above, please omit Part Four and complete Part Five. Indicate N/A for any questions not applicable.

I. UTILIZATION

		CURRENT		PROJECTED	
	Years:	20_____	20_____	20_____	20_____
A.	ESRD				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
B.	Home Health Agency				
	# Patients	_____	_____	_____	_____
	# of Visits	_____	_____	_____	_____
C.	New Equipment				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
D.	Other				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____

II. PERCENT OF GROSS REVENUE

	Historical			**Projected**	
Source of Payment	**20___**	**20___**	**20___**	**20___**	**20___**
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

III. CHARGE INFORMATION

A. List schedule of current charges related to this project.

B. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects which cost over $500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under $500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE

	Historical			**Projected**	
Source of Payment	**20___**	**20___**	**20___**	**20___**	**20___**
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

II. CHARGE INFORMATION

C. List schedule of current charges related to this project.

D. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

III. INPATIENT UTILIZATION DATA

A. Historical Data

Give information for last three (3) years for which complete data is available.

OCCUPANCY DATA

Occupancy	**Number of Beds**	**Admissions or Discharges**	**Total Patient Days**	**Percentage (%)**

	Yr ___	Yr ___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___
Medicine & Surgery												
Obstetrics												
Pediatrics												
Psychiatry												
Other												
TOTALS												

B. Projected Data
Give information to cover the first two (2) years of operation after completion of project.

OCCUPANCY DATA

Occupancy	**Number of Beds**		**Admissions or Discharges**		**Total Patient Days**		**Percentage (%)**	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Medicine & Surgery								
Obstetrics								
Pediatrics								
Psychiatry								
Other								
TOTALS								

IV. OUTPATIENT UTILIZATION DATA

A. HISTORICAL DATA

	Number of Outpatient Visits			**Percentage of Outpatient Visits**		
	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____

Clinical						
Diagnostic						
Rehabilitation						
Surgical						

B. PROJECTED DATA

	Number of Outpatient Visits		**Percentage of Outpatient Visits**	
	1st year	2nd year	1st year	2nd year
Clinical				
Diagnostic				
Rehabilitation				
Surgical				

V. A. ORGANIZATION FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE (Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) -- Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

B. PROJECT SPECIFIC FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE(Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) – Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

STATEMENT OF COMMUNITY PARTNERSHIP FOR EDUCATION AND REFERRALS

A. This section is declaration of those activities your organization performs outside of inpatient and outpatient care in the community and for the underserved population. Please indicate historical and projected data by expenditures in the columns specified below.

Services and/or Programs	**Historical Data (total dollars spent in last 3 years)**			**Projected Data (total dollars budgeted for next 2 years)**	
	Year	Year	Year	Year	Year
Health Education (nutrition, fitness, etc.					
Community service workers (school nurses, etc.)					
Health screenings					
Other					
TOTAL					

B. Please describe how the new services specified in this project application will be made available to and address the needs of the underserved community. If the project does not involve new services, please describe how the project will address the underserved population in your community.

Please briefly describe some of the current services or programs presented to the underserved in your community.

_____

_____

_____

_____

_____

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

I. ACKNOWLEDGEMENT

In submitting this application, the applicant understands and acknowledges that:

A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.

B. The issuance of a certificate of need will depend on the approval of the CON Review Board, and no attempt to provide the service or incur an obligation will be made until a bona fide certificate of need is issued.

C. The certificate of need will expire in twelve (12) months after date of issuance, unless an extension is granted pursuant to the applicable portions of the SHPDA rules and regulations.

D. The certificate of need is <u>not transferrable</u>, and any action to transfer or assign the certificate will render it null and void.

E. The applicant will notify the State Health Planning and Development Agency when a project is started, completed or abandoned.

F. The applicant shall file a progress report on each active project every six (6) months until the project is completed.

G. The applicant must comply with all state and local building codes, and failure to comply will render the certificate of need null and void.

H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.

I. Projects are limited to the work identified in the Certificate of Need <u>as issued</u>.

J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.

K. The applicant will comply with all state statutes for the protection of the environment.

L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

I. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief.

_____
Signature of Applicant

_____
Applicant's Name and Title
(Type or Print)

_____day of _____ 20_____

_____
Notary Public (Affix seal on Original)

Author: Alva M. Lambert
Statutory Authority: §§ 22-21-267, -271, -275, Code of Alabama, 1975
History: Amended: March 19, 1996; July 25, 2002; Filed: July 22, 2013; effective August 26, 2013.