



STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

NOTICE OF INTENDED ACTION

AGENCY NAME: STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
(Certificate of Need Review Board)

RULE NO. & TITLE: Appendix A Application for Extension of Certificate of Need

INTENDED ACTION:

The State Health Planning and Development Agency and the Certificate of Need Review Board propose to amend the Application for Extension of Certificate of Need.

SUBSTANCE OF PROPOSED ACTION:

This amendment to Application for Extension of Certificate of Need corrects formatting and typographical errors.

TIME, PLACE, MANNER OF PRESENTING VIEWS:

In response to this Proposed Amendment, all interested persons are invited to submit data, views, comments and/or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the Certificate of Need Review Board shall be made in writing on or before July 5, 2013, and shall be made to:

Nicole Horn, Executive Secretary
State Health Planning and Development Agency
P. O. Box 303025
Montgomery, Alabama 36130-3025

On July 17, 2013, at 10:00 a.m., the Certificate of Need Review Board shall conduct a public hearing in the State Capitol, Capitol Auditorium, 600 Dexter Avenue, Montgomery, Alabama, at which time it shall consider the Proposed Amendment, along with all written and oral submissions respecting the Proposed Amendment. Only those interested persons who have made timely written requests will be afforded the opportunity to speak.

Copies of the proposed changes are available for review at 100 North Union Street, RSA Union Building, Suite 870, Montgomery, Alabama. Phone (334) 242-4103 or visit the office Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding State holidays.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:

July 5, 2013

CONTACT PERSON AT AGENCY:

Nicole Horn

100 North Union Street

RSA Union, STE 870

Montgomery, AL 36104

(334) 242-4103

Alva M. Lambert

Alva M. Lambert, Executive Director

State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025
 Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

A filing fee in the amount of \$ _____ has been submitted with this application.

1. APPLICATION. Application is hereby made for a twelve (12) month extension of the Certificate of Need issued for the health facility described below. (All items must be completed in full before extension of Certificate of Need can be considered.)				
2. PROJECT NUMBER		3. CERTIFICATE NUMBER		4. CERTIFICATE EXPIRES
5. LEGAL NAME OF APPLICANT			6. ADDRESS OF APPLICANT	
7. NAME OF PROPOSED FACILITY			8. LOCATION OF PROPOSED FACILITY	
9. TYPE OF FACILITY			10. ANTICIPATED DATE ON WHICH OBLIGATION IS EXPECTED TO OCCUR AND/OR CONSTRUCTION STARTED	
11. ESTIMATED DATE CONSTRUCTION IS SCHEDULED FOR COMPLETION				
12. BED CAPACITY				
	Gen. Hosp.	Nursing Home SK ICF		Psychiatric
				Other _____
Existing Bed Capacity	_____	_____	_____	_____
Beds provided by New Facility Addition	_____	_____	_____	_____
Remodeling	_____	_____	_____	_____
Replacement	_____	_____	_____	_____
Capacity Upon Completion	_____	_____	_____	_____
13. ESTIMATED COST OF THE PROJECT			14. PROPOSED FINANCING OF THE PROJECT	
Construction \$ _____			Total Estimated Cost \$ _____	
Fixed Equipment \$ _____			DHEW Loan/Grant \$ _____	
Movable Equipment \$ _____			SBA Loan \$ _____	
Arch. & Eng. \$ _____			FHA Mortgage Insurance \$ _____	
Site Improvements \$ _____			Private Financing \$ _____	
Financing Charges \$ _____			Other (Specify) \$ _____	
Total Cost \$ _____				
13a. ATTACH COST ESTIMATE SIGNED BY PROJECT ARCHITECT (Required)			14a. ATTACH STATEMENT FROM FINANCING AGENCY(IES) OF LOAN FEASIBILITY (Required)	
15. SITE INFORMATION (Check One)			16. ARCHITECTURAL PROGRESS	
Acquired _____			Architect Employed _____	
Option _____			Schematic Drawings _____	
Under Construction _____			Working Drawings _____	
Not Acquired _____			Advertised for Bids _____	

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

17. BRIEF DESCRIPTION OF PROPOSED WORK. Include any proposed deletion, new or substantial change in the scope of the project as described in the Program Narrative submitted in support of the original Application.	
18. BUDGET AND UTILIZATION DATA. If there has been a material change in the estimated cost of the construction and/or operation of the facility (or if data were not submitted with the original application) it will be necessary to complete PART FIVE of the original application form. Part Five attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. COST CONTAINMENT. Attach Cost Containment Statement showing how the project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, sharing of services with other facilities, and design and construction economies.	
20. In submitting this Application, the Applicant: Understands that extension of the Certificate will depend upon compliance with minimum criteria. A. Needs of the Area as set forth in the up-dated Alabama State Health Plan. B. 1. Site Procurement: Must have acquired or holds option to purchase. Site must be inspected and approved. 2. Architectural Progress: Must have approved working drawings. 3. Financial Status: Must present evidence that appropriate and necessary financing is final and immediately available. 4. Program Narrative: Must be updated to show change in scope of service. 5. Budget and Utilization Data: Must be on file and up-to-date. Maximum increase in costs and charges must be within Cost of Living Council guidelines. 6. Cost Containment: Satisfactory statement must be on file. C. Understands that the Certificate if issued, will expire not more than twelve (12) months from date of issuance and will not be subject to further extension. D. Agrees to notify Health Development, State Health Planning and Development Agency, if and when the project is abandoned or is placed under contract. E. The Certificate of Need, if issued, is not transferable and any action on the part of the Applicant to transfer or assign the Certificate of Need will render the Certificate of Need null and void.	
21. SIGNATURE OF RESPONSIBLE OFFICER _____	22. TITLE OF OFFICER _____
23. NAME OF RESPONSIBLE OFFICER _____	24. DATE _____

Attachments:

- Cost Estimate
- Statement from Financing Agency
- Part Five Budget and Utilization Data
- Cost Containment Statement

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION

1. NAME OF APPLICANT			2. NAME OF FACILITY			
3. TYPE OF FACILITY			4. LOCATION OF FACILITY			
5. HISTORICAL DATA: Give information for last three (3) years for which complete data are available						
A. OCCUPANCY DATA						
1. ACCOMMODATION OCCUPANCY	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS	% OCCUPANCY
	YR	YR	YR	YR	YR	YR
— PRIVATE MEDICINE AND SURGERY						
SEMI-PRIVATE OBSTETRICS						
—WARD PEDIATRICS						
TOTAL SPSYCHIATRY						
2. CLINICAL SERVICES OTHER	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS	% OCCUPANCY
	YR	YR	YR	YR	YR	YR
TOTALS						
— MEDICINE AND SURGERY						
— OBSTETRICS						
— PEDIATRICS						
— PSYCHIATRY						
— OTHER						
— TOTALS						
B. SOURCE OF PAYMENT PERCENT OF GROSS REVENUE						
	YR _____		YR _____		YR _____	
BLUE CROSS						
OTHER INSURANCE						
MEDICARE						
MEDICAID						
SELF-PAY						
FREE CARE						
OTHER						
SUBTOTAL						
BAD DEBTS			%		%	%
TOTALS			100%		100%	100%

HD-161-E Revised (4-975-13)
 BUDGET AND UTILIZATION DATA
 5. HISTORICAL DATA (Cont'd)

2. NAME OF FACILITY _____

C. Statement of Income and Expense (Give information for last — three (3) years for which complete data are available.)	20____ Total	20____ Total	20____ Total	20____ Per Diem
Revenue from Services to Patients				
Inpatient Services				
Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue				
Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue				
Contract Adjustments				
Discounts/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectibles				
Total Deductions				
Net Operating Revenue				
Operating Expenses				
Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure				
Retirement of Principal				
Interest				
Total Capital Expenditure				
Total Expenses (Operating and Capital)				
Operating Income (Loss)				
Other Revenue (Expense) - Net				
Net Income (Loss)				

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION DATA

1. NAME OF APPLICANT		2. NAME OF FACILITY			
3. TYPE OF FACILITY		4. LOCATION OF FACILITY			
5. PROJECTED DATA: Give information projected to cover the first two (2) years of operation after completion of project.					
A. OCCUPANCY DATA					
I. OCCUPANCY		NUMBER OF BEDS	ADMISSIONS OR DISCHARGES	TOTAL PATIENT DAYS	% OCCUPANCY
	<u>1stst Year</u>	<u>2nd 2nd Year</u>	<u>1st 1st Year</u> <u>2ndnd Year</u>	<u>1stst Year</u> - <u>2ndnd Year</u>	<u>1st st Year</u> - <u>2nd nd Year</u>
<u>MEDICINE AND SURGERY</u>					
<u>OBSTETRICS</u>					
<u>PEDIATRICS</u>					
<u>PSYCHIATRY</u>					
<u>OTHER</u>					
<u>TOTALS</u>					
PERCENT OF GROSS REVENUE					
B. SOURCE OF PAYMENT					
	YR _____		YR _____		
<u>BLUE CROSS</u>					
<u>OTHER INSURANCE</u>					
<u>MEDICARE</u>					
<u>MEDICAID</u>					
<u>SELF-PAY</u>					
<u>FREE CARE</u>					
<u>OTHER</u>					
<u>SUBTOTAL</u>					
<u>BAD DEBTS</u>			%	%	
<u>TOTALS</u>					
			100%	100%	
	YR _____		YR _____		
<u>BLUE CROSS</u>					YR = = = = =

— OTHER INSURANCE			
— MEDICARE			
— MEDICAID			
— SELF-PAY			
— FREE CARE			
— OTHER			
===== SUBTOTAL			
— BAD DEBTS	===== %	===== %	===== %
===== TOTALS	===== 100%	===== 100%	===== 100%

Note: Include both inpatient and outpatient data

1. NAME OF APPLICANT

2. NAME OF FACILITY

3. TYPE OF FACILITY

4. LOCATION OF FACILITY

6. PROJECTED DATA: Give information projected to cover the first two (2) years of operation after completion of project.

A. OCCUPANCY DATA

1. ACCOMMODATION

ADMISSIONS TOTAL
NUMBER OF BEDS OR DISCHARGES PATIENT DAYS

OCCUPANCY

1st YEAR

2nd YEAR 1st YEAR 2nd YEAR 1st YEAR 2nd YEAR 1st YEAR 2nd YEAR

PRIVATE

SEMI-PRIVATE

WARD

TOTALS

2. CLINICAL SERVICES

ADMISSIONS TOTAL
NUMBER OF BEDS OR DISCHARGES PATIENT DAYS

OCCUPANCY

1st YEAR

2nd YEAR 1st YEAR 2nd YEAR 1st YEAR 2nd YEAR

YEAR

MEDICINE AND SURGERY

OBSTETRICS

PEDIATRICS

PSYCHIATRY

OTHER

TOTALS

PERCENT OF GROSS REVENUE

B. SOURCE OF PAYMENT

YR

YR

BLUE CROSS

OTHER INSURANCE

MEDICARE

MEDICAID

SELF-PAY

FREE CARE

OTHER

SUBTOTAL

% %

BAD DEBTS

TOTAL

100% 100%

NOTE: Include both inpatient and outpatient data.

NAME OF FACILITY _____

6. PROJECTED DATA ~~rojected Data~~ (Cont'd)

C. Statement of Projected Income and Expenses (First two (2) years after completion _____ completion of project.)	20____		20____	
	Total	Per Diem	Total	Per Diem
Revenue from Services to Patients				
Inpatient Services				
Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue				
Recoveries				
Other				
<u>Gross Operating Revenue</u>				
Deductions from Operating Revenue				
Contract Adjustments				
Discount/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
<u>Total Deductions</u>				
Net Operating Revenue				
Operating Expenses				
Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
<u>Total Operating Expenses</u>				
Capital Expenditure				
Incurred Prior to this Project				
- Retirement of Principal				
- Interest				
This Project				
- Retirement of Principal				
- Interest				
<u>Total Capital Expenditure</u>				
Total Expenses (Operating & Capital)				
Operating Income (Loss)				
Other Revenue (Expense) – Net				

BUDGET AND UTILIZATION

7. INFORMATION REGARDING PROPOSED FINANCING

Total amount to be borrowed \$ _____

Anticipated interest rate _____ %

Term of loan _____ years

Method of calculating interest and principal payments:

8. ATTACHMENTS

- (1) Schedule of current charges.
- (2) Schedule of proposed charges after completion of this project.
- (3) State of existing capital indebtedness.
- (4) Schedule showing projected annual depreciation for buildings, fixed equipment, and movable equipment.