APA-1
11/96

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 410 Department or Agency State Health Planning and Development Agency (Certificate of Need Review Board)
Rule No. Appendix A
Rule Title: Application for Extension of Certificate of Need
_____ New X Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? NO

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? YES

Is there another, less restrictive method of regulation available that could adequately protect the public? NO

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? NO

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? YES

* *

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

* *

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer Ava M. Lambert

Date 5-21-13

DATE FILED
REC'D & FILED (STAMP)

MAY 21 2013

LEGISLATIVE REF SERVICE

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, Executive Director

BHD-162
(8-77)
Revised (~~4-975-13~~)

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	Nursing Home 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 _____

BHD-162
Revised (~~4-975-13~~)

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: _____ Yes _____ 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

HD-161-E
Revised (4-975-13)

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	YR	YR	YR	YR	YR	YR
~~PRIVATE~~ MEDICINE AND SURGERY												
~~SEMI-PRIVATE~~ OBSTETRICS												
~~WARD~~ PEDIATRICS												
~~TOTALS~~PSYCHIATRY												
~~2. CLINICAL SERVICES~~ OTHER	~~NUMBER OF BEDS~~			~~ADMISSIONS OR DISCHARGES~~			~~TOTAL PATIENT DAYS~~			~~% OCCUPANCY~~		
TOTALS	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~	~~YR~~
~~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 Uncollectaibles				
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)				

HD-161-E
Revised (4-975-13)

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

1. OCCUPANCY	NUMBER OF BEDS	ADMISSIONS OR DISCHARGES	TOTAL PATIENT DAYS	% OCCUPANCY
	1stst Year 2nd ~~2nd~~ Year	1st ~~1st~~ Year 2ndnd Year	1stst Year - 2ndnd Year	1st st Year ~~nd~~ 2nd Year
MEDICINE AND SURGERY				
OBSTETRICS				
PEDIATRICS				
PSYCHIATRY				
OTHER				
TOTALS				

B. SOURCE OF PAYMENT

PERCENT OF GROSS REVENUE

	YR _____	YR _____
BLUE CROSS		
OTHER INSURANCE		
MEDICARE		
MEDICAID		
SELF-PAY		
FREE CARE		
OTHER		
SUBTOTAL		
BAD DEBTS	%	%
TOTALS		
	100%	100%

	~~YR~~ _____	~~YR~~ _____	~~YR~~
~~BLUE CROSS~~			

~~OTHER INSURANCE~~			
~~MEDICARE~~			
~~MEDICAID~~			
~~SELF PAY~~			
~~FREE CARE~~			
~~OTHER~~			
~~SUBTOTAL~~			
~~BAD DEBTS~~	~~%~~	~~%~~	%
~~TOTALS~~	~~100%~~	~~100%~~	~~10~~ 0%

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 OCCUPANCY	ADMISSIONS OR DISCHARGES		TOTAL NUMBER OF BEDS		PATIENT DAYS	
	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR
PRIVATE						
SEMI PRIVATE						
WARD						
TOTALS						

2. CLINICAL SERVICES OCCUPANCY	ADMISSIONS OR DISCHARGES		TOTAL NUMBER OF BEDS		PATIENT DAYS	
	1st YEAR	2nd YEAR	1ST YEAR	2ND YEAR	1ST YEAR	2ND YEAR
MEDICINE AND SURGERY						
OBSTETRICS						
PEDIATRICS						
PSYCHIATRY						
OTHER						
TOTALS						

B. SOURCE OF PAYMENT — PERCENT OF GROSS REVENUE	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.

HD-161-E Revised (4-975-13)
BUDGET AND UTILIZATION

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				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discount/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
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 Incurred Prior to this Project - Retirement of Principal				
- Interest				
This Project - Retirement of Principal				
- Interest				
Total Capital Expenditure				
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.