

**ALABAMA
CERTIFICATE OF NEED
APPLICATION**

For Staff Use Only

INSTRUCTIONS: Please submit an original and twelve (12) copies 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)

Project # _____
Date Rec. _____
Rec by: _____

Attached is a check in the amount of \$ _____
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 _____ | _____ Major Medical Equipment
Type _____ |
| _____ New Service
Type _____ | _____ Termination of Service or Facility |
| _____ Construction/Expansion/Renovation | _____ Other Capital Expenditure
Type _____ |
| _____ Change in Service | |

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

A.	Federal	Amount	Source
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 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	Years:	20_____	CURRENT 20_____	PROJECTED 20_____	20_____
	A. ESRD					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____
	B. Home Health Agency or Hospice Provider					
	# Patients		_____	_____	_____	_____
	# of Visits		_____	_____	_____	_____
	C. New Equipment					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____
	D. Other					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____

II. Percent of Gross Revenue

Source of Payment	Historical		Projected		
	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 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 not transferrable, 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 as issued.
- 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, and August 19, 2009